

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36001

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

| | | | | | |
|---|---|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Unknown 99-209 | | 2. Date of Death Month Day Year SEPTEMBER 9, 1999 | | 3. Time of Death 1500 PM | |
| 4a. Facility Name (If not institution, give street and number) 214 NORTH AMITY STREET | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | |
| 5. Social Security Number unknown | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F unknown | 7. Age (In yrs. last birthday) unknown Yrs. | 8. Date of Birth (Month, Day, Year) unknown | 9. Birthplace (State or Foreign Country) unknown | |
| Usual Residence of Decedent | | | | | |
| 10a. State unknown | 10b. County unknown | 10c. City, Town or Location unknown | | 10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No unknown | |
| 10e. Street and Number unknown | | 10f. Zip Code unknown | | 10g. Citizen of What Country? unknown | |
| 11. Marital Status unknown <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: unknown | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No Specify: unknown | |
| 14. Race - American Indian, Black, White, etc. Specify: unknown | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown | | | |
| 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown | | 16b. Kind of Business/Industry unknown | | | |
| 17. Father's Name (First, Middle, Last) unknown | | 18. Mother's Name (First, Middle, Maiden Surname) unknown | | | |
| 19a. Informant's Name/Relationship (Type, Print) O.C.M.E. | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street, Baltimore, Maryland 21201 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Blunt Force Injuries Due to (or as a consequence of): OF Head Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 9/9/99 Found | | 28b. Time of Injury 1500 M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Subject Assaulted | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) House (Found) 214 N. Amity St. Baltimore, Md. | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) SEPTEMBER 10, 1999 | |
| 29b. Signature and title of certifier J. Pustanay M.D. | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | |
| 31. Date filed (Month, Day, Year) NOV 16 1999 | | 32. Registrar's Signature B. Spauld | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

NOV 1 9 1966

99-4950-510
UNKNOWN 99-187

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36002

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Unknown 99-187

2. Date of Death

Month Day Year
AUGUST 21, 1999

3. Time of Death

5:45 PM

4a. Facility Name (If not institution, give street and number)

2100 SOUTH HANOVER STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

unknown

6. Sex unknown Age (In yrs. last birthday)

1 ☐ M 2 ☐ F

unknown Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
unknown

9. Birthplace (State or Foreign

Country)
unknown

Usual Residence of Decedent

10a. State

unknown

10b. County

unknown

10c. City, Town or Location

unknown

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

unknown

10e. Street and Number

unknown

10f. Zip Code

unknown

10g. Citizen of What Country?

unknown

11. Marital Status: unknown

1 ☐ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give

Year or Dates: unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☐ No Specify: unknown

14. Race - American Indian,

Bleck, White, etc.

Specify: unknown

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4or 5+)

unknown

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Summe)

unknown

19a. Informant's Name/Relationship (Type, Print)

O.C.M. E.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 Penn Street, Baltimore, MD 21201

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) in state

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, Maryland 21201

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate

Interval Between

Onset and Death

Immediate Cause (Final

disease or condition

resulting in death)

a. PROBABLE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

XX Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

XX Yes 2 ☐ No

25. Was case referred to medical examiner?

XX Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Manner of Death

XX Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Margarita A. Korell, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

10-8-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARGARITA A. KORELL, M.D. 111 PENN STREET, BALTIMORE, MARYLAND 21201

31. Date filed (Month, Day, Year)

NOV 16 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

[Faint, illegible handwritten text]

NOV 1 8 1966

99 36003

Reg. No.

ORIGINAL

NOV 1 8 1933

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36004

| | | | | | | | | | |
|---|--|---|--------------------------|---|---|--|---|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) PATRICK J WALLACE | | | | 2. Date of Death Month Day Year NOVEMBER 14 1999 | | 3. Time of Death 2:33 p.m. | | |
| | 4a. Facility Name (If not institution, give street and number) BALTIMORE VA MEDICAL CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 202-05-9480 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 2, 1921 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore Co. | | 10c. City, Town or Location Parkville | | | 10d. Inside City Limits 1 Yes 2 No | | |
| 10e. Street and Number 2807 Upridge Court Apt. D | | | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? United States | | | |
| 11. Marital Status 1 X Navar Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance | | | 16b. Kind of Business/Industry Baltimore City | | |
| 17. Father's Name (First, Middle, Last) Patrick J. Wallace | | | | 18. Mother's Name (First, Middle, Maiden Surname) Nellie L. O'Connor | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Marie A. Folan (sister) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2807 Upridge Ct. Apt. D Baltimore, MD 21234 | | | | | |
| 20a. Method of Disposition 1 X Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery | | 20c. Location - City or Town, State 11/17/99 Baltimore, Maryland | | | |
| 21. Signature of Funeral Service Licensee Michael E. Canapp | | | | 22. Name and Address of Facility LEONARD J. RUCK, INC. 5305 Harford Road Baltimore, MD 21214 | | | | | |
| 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): c. PNEUMONECTOMY Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 X Probably 4 Unknown | | | | | | | | | |
| 24a. Was an autopsy performed? 1 Yes 2 X No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 Yes 2 X No | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Thomas E. Mason | | 29c. License number 211771 | | 29d. Date signed (Month, Day, Year) NOVEMBER 14, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS E. MASON, 10 N. GREENE ST, BALTIMORE, MD 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 16 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

RECEIVED

NOV 1 1952

FROM

TO

SUBJECT

REMARKS

ANALYST

DATE

TIME

LOCATION

INSTRUMENT

OPERATOR

ASSISTANT

REMARKS

ANALYST

DATE

TIME

LOCATION

NOV 1 1952

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36005

| | | | | | | | |
|--|---|---|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CATHERINE DEGNAN WALTJEN | | | | 2. Date of Death Month Day Year NOVEMBER 14, 1999 | | 3. Time of Death 8:31 PM |
| | 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore |
| Funeral Director | 5. Social Security Number 215-16-1549 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 28, 1921 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County N/A | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10a. Street and Number 3 Goodale Place | | | 10f. Zip Code 21212 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | |
| | 17. Father's Name (First, Middle, Last) Joseph P Degnan | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret McMahon | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Norman V. Waltjen, Jr. (husband) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Goodale Place Baltimore, Maryland 21212 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory | | Date 11-16-99 | 20c. Location - City or Town, State Baltimore, Maryland | |
| | 21. Signature of Funeral Service Licensee George J. Ferraro | | | 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ANOXIC ENCEPHALOPATHY Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CEREBROVASCULAR ACCIDENTS | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier Francis Khoo | | | 29c. License number D30263 | | 29d. Date signed (Month, Day, Year) 11-15-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHOO, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 16 1999 | | 32. Registrar's Signature Benita B. Spauld | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

2001 A 1

VOM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William H. Wahl

2. Date of Death

November 11, 1999

3. Time of Death

11:00PM

4a. Facility Name (If not institution, give street and number)

1233 Vogt Ave.

4b. City, Town, or Location of Death

Arbutus

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

217-22-7883

6. Sex

10 M 20 F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

February 13, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Arbutus

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

1233 Vogt Ave.

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

10 Never Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever In U.S. Armed Forces?

10 Yes 20 No
If Yes, Give Year or Dates: 5/2/46
3/2/48

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (10-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Fire fighter

16b. Kind of Business/Industry

City Government

17. Father's Name (First, Middle, Last)

Michael Wahl

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Butcher

19a. Informant's Name/Relationship (Type, Print)

Lawrence Cremen/executor

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7 Cutlass Dr. Berlin MD 21811

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

11/15/99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Sean J. Imbrey

22. Name and Address of Facility

Ambrose Funeral Home Inc.
1328 Sulphur Spring Rd. Arbutus MD 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. —

Due to (or as a consequence of):

d. —

Approximate Interval Between Onset and Death

Per minutes

Several years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

26. Place of Death (Check only one)

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending investigation
20 Accident 60 Could not be determined
30 Suicide 40 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Horizon Moghleh, M.D.

29c. License number

D0017720

29d. Date signed (Month, Day, Year)

11/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bon Secours Hospital, 200 W. Balto St., 21223

31. Date filed (Month, Day, Year)

NOV 16 1999

32. Registrar's Signature

Dana B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

MON 1 1950

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36007

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ERMA JORDAN WILLIAMS

2. Date of Death

Month Day Year
NOVEMBER 9 19993. Time of Death
11:45 P.M.

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

217-14-6622

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Aug. 28, 1909

9. Birthplace (State or Foreign

Country)
Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3014 Second Avenue

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9th grade

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

John Henry Jordan

18. Mother's Name (First, Middle, Maiden Summe)

Marie Riehl

19a. Informant's Name/Relationship (Type, Print)

Ruth D. Megary

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2008 Wintergreen Place Baltimore, Md. 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Parkwood Cemetery 11-12-1999

Date

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lassahn Funeral Home

7401 Belair Rd. Baltimore, Md. 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. SMALL BOWEL OBSTRUCTION

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

ACUTE ON CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D37254

29d. Date signed (Month, Day, Year)

11/10/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOON P. LIM M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

NOV 16 1999

32. Registrar's Signature

Brenda S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NOV 1 1955

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36008

| | | | | | | | | | | |
|--|--|---|---|--|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Norman Whitehead | | | | | | 2. Date of Death Month Day Year OCTOBER 28, 1999 | | 3. Time of Death 0732 AM | |
| | 4a. Facility Name (If not institution, give street and number) 1455 LIGHT STREET | | | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 219-30-4346 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 65 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 2, 1934 | | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Unk. | | 10b. County unknown | | 10c. City, Town or Location unknown | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10a. Street and Number Unknown | | | | 10f. Zip Code Unknown | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown | | | 16b. Kind of Business/Industry unknown | | |
| | 17. Father's Name (First, Middle, Last) unknown | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) unknown | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Michele Whitehead/daughter | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2023 Griffis Ave., Baltimore, MD 21230 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | | | |
| | 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street, Baltimore, MD 21201 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| | <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Arteriosclerotic Cardiovascular Disease</p> <p>Due to (or as a consequence of):</p> </div> <div style="width: 30%;"> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> <div style="width: 30%;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CACHEXIA | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier Monique Dorey | | | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) OCTOBER 28, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year) NOV 16 1999 | | 32. Registrar's Signature [Signature] | | | | | | |

Handwritten signature

NOV 1 1930

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36009

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edith Alberta Winter | | | | 2. Date of Death Month Day Year November 11, 1999 | | 3. Time of Death 5:20 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number) 2451 Harriet Avenue | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 300-48-2933 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 68 Yrs. | 8. Date of Birth (Month, Day, Year) April 19, 1931 | 9. Birthplace (State or Foreign Country) W. Virginia | | | |
| | Usual Residence of Decedent | | | | 10a. State Md. | | 10b. County N/A | | |
| To Be Completed by Funeral Director | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| | 10e. Street and Number 2451 Harriet Avenue | | | | 10f. Zip Code 21230 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Home | | | | |
| | 17. Father's Name (First, Middle, Last) William Daniel Holt | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Ellen Johnson | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Linda Hatfield (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 244 Gilbert, W. Virginia 25601 | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park | | Date 11/15/99 | | 20c. Location - City or Town, State Glen Burnie, Maryland | | |
| | 21. Signature of Funeral Service Licensee Kevin E. Ecker | | | | 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225 | | | | |
| | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Metastatic Small Cell Lung Carcinoma</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 4 months | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Emphysema</u> <u>Coronary Artery Disease</u> | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier Julie R Brahmer, MD | | | | 29c. License number D0051770 | | 29d. Date signed (Month, Day, Year) November 12 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julie R Brahmer, MD Johns Hopkins Hospital Baltimore, MD 21287 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 16 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

974

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36010

Amend Item#26 perPhyG777 11/16/99 EW

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Jane Wade

2. Date of Death

November 13, 1999

3. Time of Death

10:45 P.M.

4a. Facility Name (If not institution, give street and number)

Hospice of the Chesapeake Care Center

4b. City, Town, or Location of Death

Linthicum

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

214-22-0803

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Aug. 6, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1600 Popland Street

10f. Zip Code

21226

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Vault Manager

16b. Kind of Business/Industry

Md. National Bank

17. Father's Name (First, Middle, Last)

Wilber John Foxwell

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Walters

19a. Informant's Name/Relationship (Type, Print)

David J. Wade (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

163 Windsor Court Hanover, Pennsylvania 17331

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

11/17/99 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Kevin E. Ecker

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.A.
237 E. Patapsco Avenue Baltimore, Maryland 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. BREAST CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

15 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BRAIN METASTASES

BONE METASTASES

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) Hospice of Chesapeake

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D29373

29d. Date signed (Month, Day, Year)

11/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERIC J. SEIFTER 10755 FALLS RD, SUITE 200 LUTHERVILLE, MD 21093

State
Registrar

31. Date filed (Month, Day, Year)

NOV 16 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

AH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36011

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CHARLES R WIEGAND | | | | 2. Date of Death Month Day Year NOV. 14 1999 | | 3. Time of Death 2:45 am | |
| | 4a. Facility Name (If not institution, give street and number) 440 Oriole Road | | | | 4b. City, Town, or Location of Death Eastpoint | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 218-05-4158 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug 24 1918 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Eastpoint | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 440 Oriole Road | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter | | 16b. Kind of Business/Industry General Ship Repair | | | |
| | 17. Father's Name (First, Middle, Last) Albert Wiegand | | | | 18. Mother's Name (First, Middle, Maiden Surname) Anna Primus | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Violet Wiegand / wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 440 Oriole Road Baltimore Md. 21224 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Cemetery | | Date 11/17/99 | | 20c. Location - City or Town, State Baltimore Md. | |
| | 21. Signature of Funeral Service Licensee R. Terry Connelly | | | | 22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Metastatic Lung CA Due to (or as a consequence of): | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| | 29b. Signature and title of certifier Walle | | | | 29c. License number D26835 | | 29d. Date signed (Month, Day, Year) 11-15-99 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A. Walle 1576 Merriott Blvd | | | | | | | |
| | 31. Date filed (Month, Day, Year) NOV 16 1999 | | | | 32. Registrar's Signature Sparks | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36012

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Wilson Whalen

2. Date of Death

November 11, 1999

3. Time of Death

5:45 AM

4a. Facility Name (If not institution, give street and number)

2108 Pelham Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

217-07-9501

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Jan. 6, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4322 Brehms Lane

10f. Zip Code

21206

10g. Citizen of What Country?

U. S. A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Police Officer

16b. Kind of Business/Industry

Baltimore City Police Department

17. Father's Name (First, Middle, Last)

Lawrence Whalen

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Jeffrey

19a. Informant's Name/Relationship (Type, Print)

Thomas Brian Whalen (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8815 Spring Road, Baltimore, Md. 21234

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

11/15/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

► Brian A. Whalen

22. Name and Address of Facility

Schimunek Funeral Home Inc.
3331 Brehms Lane, Baltimore, Maryland 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Emphysema

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☒ Other (Specify) *at home*

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Albert J. Diaz MD

29c. License number

D004126

29d. Date signed (Month, Day, Year)

11/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Albert J. Diaz MD 7401 OSLER DR #103 - Towson MD 21204

State
Registrar

31. Date filed (Month, Day, Year)

NOV 16 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten signature

CEB 8 I VOM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#19b&b PER A.B. G777 11-17-99 J.A.

Certificate of Death

Reg. No. 99 36013

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
DirectorPhysician
/Medical
Examiner

| | | | | | |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Frank Brennon | | 2. Date of Death Month Day Year October 5, 1999 | | 3. Time of Death 1:11 p.m. | |
| 4a. Facility Name (If not institution, give street and number) 2241 Annapolis Road | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A |
| 5. Social Security Number unknown | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 70 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) unknown |
| 9. Birthplace (State or Foreign Country) unknown | | | | | |
| Usual Residence of Decedent | | 10a. State unknown | | 10b. County unknown | |
| 10c. City, Town or Location unknown | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 2241 Annapolis Road | | 10f. Zip Code 21230 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status unknown <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: unknown | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: unknown | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown | |
| 16b. Kind of Business/Industry unknown | | 17. Father's Name (First, Middle, Last) unknown | | 18. Mother's Name (First, Middle, Maiden Summa) unknown | |
| 19a. Informant's Name/Relationship (Type, Print) unknown O.C.M.E. | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown 111 PENN STREET, BALTIMORE, MARYLAND 21201 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state | | 20b. Place of Disposition (Name of cemetery, crematory or other place) State Anatomy Board | | 20c. Location - City or Town, State Baltimore, MD 21201 | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St Baltimore, MD 21201 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed? Limited <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier Stephen S. Radentz, MD | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) October 6, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 16 1999 | | 32. Registrar's Signature Barbara B. Sparks | | | |

Handwritten signature

NOV 1 6 1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36014

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Pearl Brown

2. Date of Death

Month Day Year

November 12 1999

3. Time of Death

0615

4a. Facility Name (If not institution, give street and number)

Deaton University of Maryland Medicine Baltimore

4b. City, Town, or Location of Death

4c. County of Death

NA

Funeral
Director

5. Social Security Number

213-34-8894

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

62

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

02-20-37

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1105 Myrtle Avenue

10f. Zip Code

21201

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7th Grade

College (1-4or 5+)

NA

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Never-worked

16b. Kind of Business/Industry

Unemployed

17. Father's Name (First, Middle, Last)

Johnny Williams

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Smith

19a. Informant's Name/Relationship (Type, Print)

Wilbert Brown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1105 Myrtle Avenue Baltimore, Maryland

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arbutus Mem. Pk. Cem. 11-17-99 Arbutus, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Bennett S. Johnson

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

12 hrs

b.

Cerebrovascular accident

Due to (or as a consequence of):

10 yrs

c.

Hypertension

Due to (or as a consequence of):

15 yrs

d.

Diabetes mellitus

11

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Respiratory failure. Decubitus ulcers

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Bennett S. Johnson

29c. License number

D-30494

29d. Date signed (Month, Day, Year)

11-13-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. DESA In Deaton Medical Center 611 south charles street Baltimore MD 21230

State
Registrar

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

Bennett S. Johnson

Physician Name: Pearl Brown
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

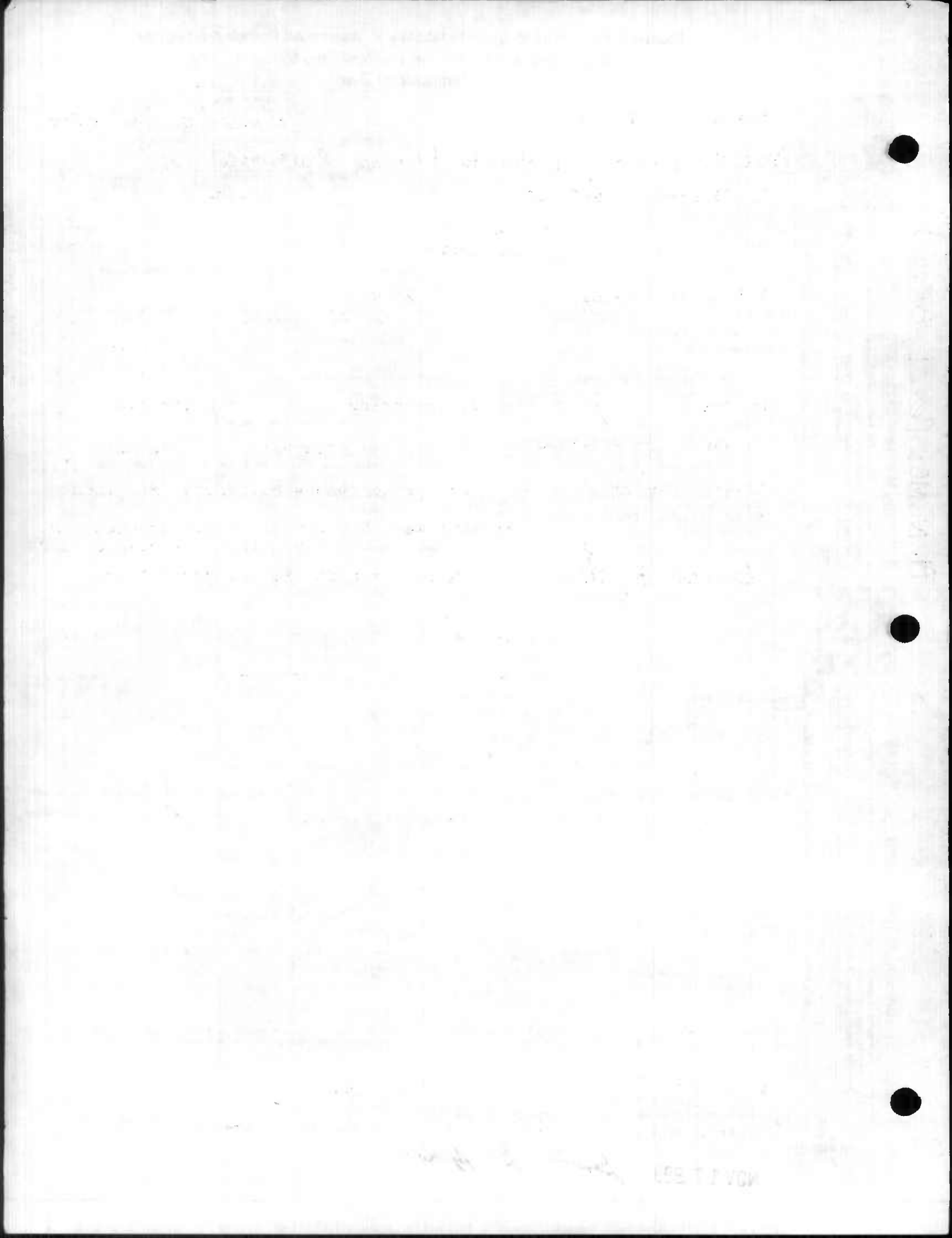
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



99 36015

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36016

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Adeline Bassetti

2. Date of Death
Month Day Year
November 12, 19993. Time of Death
7:15pm

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219-12-7952

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 18, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7840 Shepherd Ave.

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Gustav O. Birkelien

18. Mother's Name (First, Middle, Maiden Surname)

Ida E. Simonsen

19a. Informant's Name/Relationship (Type, Print)

Nicholas J. Bassetti-Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7840 Shepherd Ave. Baltimore, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

Date

Nov. 10, 1999

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Heather Cain

22. Name and Address of Facility

Evans Chapel of Memories
8800 Harford Road
Baltimore, Maryland 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. VULVAR cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

W.A. Riley, MD

29c. License number

125205

29d. Date signed (Month, Day, Year)

November 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley GMC 670 N. Charles St. Balto. MD 21204

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

[Signature]

State
Registrar

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
Bassetti, Ruth November 12, 1999 7:13 pm
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36017

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Katherine E. Bachmann

2. Date of Death

NOVEMBER 14, 1999

Day Year

3. Time of Death

10:15 PM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

215-22-6401

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 29, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Md

10b. County

10c. City, Town or Location
Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4006 Hamilton Ave.

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

home

17. Father's Name (First, Middle, Last)

Philip F. Airey

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Brown

19a. Informant's Name/Relationship (Type, Print)

Patricia E. Stephenson - daug.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3419 Northwind Rd. Baltimore Md 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

Nov. 18 1999

20c. Location - City or Town, State

Parkville Maryland

21. Signature of Funeral Service Licensee

Keida S. Wells

22. Name and Address of Facility

Evans Funeral Chapel
8800 Harford Rd. Baltimore, Md 21234

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PNEUMONIA

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death
1 WEEK

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Francis Khoo

29c. License number

D30263

29d. Date signed (Month, Day, Year)

11-15-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

Benjamin Sparks

State
Registrar

Baltimore, Maryland 21215-0020

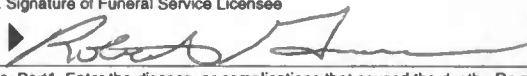
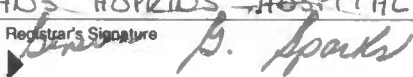
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36018

| | | | | | |
|---|---|---|--|--|-----------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) I MAX BAUMANN | | 2. Date of Death Month NOVEMBER Day 10 Year 1999 | | 3. Time of Death 17:30 |
| | 4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 112-03-8393 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 81 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) MAR. 9, 1918 | | 9. Birthplace (State or Foreign Country) NY | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location OWINGS MILLS | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 12104 VELVET HILLS DRIVE | | 10f. Zip Code 21117 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PRINCIPAL | | 16b. Kind of Business/Industry EDUCATION | |
| 17. Father's Name (First, Middle, Last) HERMAN BAUMANN | | 18. Mother's Name (First, Middle, Maiden Surname) RAY ESTELLE HOWELL | | | |
| 19a. Informant's Name/Relationship (Type, Print) DIANA BAUMANN / WIFE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12104 VELVET HILLS DRIVE - OWINGS MILLS, MD 21117 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW CEMETERY | | 20c. Location - City or Town, State 11/14/99 REISTERSTOWN, MD | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | | | | |
| a. SEPSIS Due to (or as a consequence of): | | | | | |
| b. CAVERNOUS SINUS THROMBOSIS Due to (or as a consequence of): | | | | | |
| c. Due to (or as a consequence of): | | | | | |
| d. Due to (or as a consequence of): | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) NOVEMBER 12, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID ZAKS, MD, JOHNS HOPKINS HOSPITAL, BALTIMORE, MARYLAND 21287 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature  | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36019

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) LEONARD W. BENESH 2. Date of Death Month Day Year NOVEMBER 14, 1999 3. Time of Death 2:41 A.M.

4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL 4b. City, Town, or Location of Death BALTIMORE 4c. County of Death N/A

Funeral
Director

5. Social Security Number 212-16-9811 6. Sex 1 ☒ M 2 ☐ F 7. Age (In yrs. last birthday) 80 Yrs. 8. Date of Birth (Month, Day, Year) DEC. 5, 1918 9. Birthplace (State or Foreign Country) MD

Usual Residence of Decedent 10a. State MD 10b. County N/A 10c. City, Town or Location BALTIMORE 10d. Inside City Limits 1 ☒ Yes 2 ☐ No

10e. Street and Number 6402 APOLLO DRIVE #C 10f. Zip Code 21209 10g. Citizen of What Country? U.S.A.

11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANAGER 16b. Kind of Business/Industry RETAIL CLOTHING

17. Father's Name (First, Middle, Last) HARRY H. BENESH 18. Mother's Name (First, Middle, Maiden Summa) LEAH GOLDMAN

19a. Informant's Name/Relationship (Type, Print) ADELE BENESH / WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6402 APOLLO DRIVE #C - BALTIMORE, MD 21209

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) CHIZUK AMONO ARLINGTON 20c. Location - City or Town, State 11/15/99 BALTIMORE, MD

21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTI SYSTEM ORGAN FAILURE Due to (or as a consequence of): b. GASTRO INTESTINAL BLEED Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANOXIC BRAIN INJURY 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 29c. License number AS2402321 MN2950 29d. Date signed (Month, Day, Year) NOVEMBER 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6508 SANZO ROAD BALTIMORE, MD 21209

31. Date filed (Month, Day, Year) NOV 17 1999 32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36020

AMENDED ITEMS 18 & 20b PER FH G777 11/17/99 AH

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|---|--|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Susie Bell Boyd | | | | 2. Date of Death Month Day Year November 12 99 | | 3. Time of Death 10:53 AM | |
| | 4a. Facility Name (If not institution, give street and number) Union Memorial Hospital | | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 213-26-3435 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 77 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Feb. 12, 1922 | 9. Birthplace (State or Foreign Country) NC |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State NC | | 10b. County Warren | | 10c. City, Town or Location Littleton | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number Route 3, Box 82 | | | | 10f. Zip Code 27850 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | |
| 17. Father's Name (First, Middle, Last) Eddie Green | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Georgina GREGORY unk. | | | |
| 19a. Informant's Name/Relationship (Type, Print) Wendell Baylock / Grandson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4703 Woodlea Avenue, Baltimore MD 21206 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) PLEASANT ZION Olive Grove Cemetery | | Date Nov. 20, 1999 | | 20c. Location - City or Town, State Littleton, NC | |
| 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. | | | | 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 | | | | |
| Physician /Medical Examiner | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) Pancreatic CANCER | | | | | | | 1 month. |
| | Due to (or as a consequence of): Hypertension | | | | | | | 10 years. |
| | Due to (or as a consequence of): Diabetes | | | | | | | 10 years. |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | | | 29c. License number AT-2438946-P23 | | 29d. Date signed (Month, Day, Year) Nov 12-99 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) FIRAS F. MUSSA MD. 201 E UNIV PKWY Baltimore MD 21218 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | | | 32. Registrar's Signature [Signature] | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

[Faint, illegible handwritten text covering the page]

Handwritten signature or name at the bottom center.

NOV 5 1908

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36021

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Michael A. Broseker Sr

2. Date of Death

Nov 14 1999

3. Time of Death

11:15 pm

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

219-80-5104

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

39

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 5, 1960

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

119 S. Jerome Parkway

10f. Zip Code

21060

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Shipping Clerk

16b. Kind of Business/Industry

Distribution

17. Father's Name (First, Middle, Last)

Charles L. Broseker

18. Mother's Name (First, Middle, Maiden Surname)

Mary R. Duvall

19a. Informant's Name/Relationship (Type, Print)

Sandra L. Broseker/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

909 Genine Drive, Glen Burnie, Maryland 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

Nov. 18
1999

20c. Location - City or Town, State

Brooklyn Park, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy., S.E., Glen Burnie, MD 2106123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. cardiac dysrhythmia

Due to (or as a consequence of):

b. cocaine overdose

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

12 hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☒ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)
Nov 14 1999

28b. Time of Injury

2:00 pm

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

cocaine overdose

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

home

28f. Location (Street and Number or Rural Route Number,
City or Town, State)119 South Jerome Pkwy Glen
Burnie29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D28640

29d. Date signed (Month, Day, Year)

Nov 15, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

2414 Hightee Ct Crofton MD 21114

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36022

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JULIA BLOOM | | | | 2. Date of Death Month Day Year NOVEMBER 7, 1999 | | 3. Time of Death 6:37 AM | |
| | 4a. Facility Name (If not institution, give street and number) 725 MT. WILSON LANE #235 | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 215-09-0850 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 93 Yrs. | | 8. Date of Birth (Month, Day, Year) OCT. 19, 1906 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 725 MT. WILSON LANE #235 | | 10f. Zip Code 21208 | |
| | 10g. Citizen of What Country? U.S.A. | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | | | 16b. Kind of Business/Industry OWN HOME | | 17. Father's Name (First, Middle, Last) DAVID HEYMAN | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname) MOLLIE ROSENBERG | | | | 19a. Informant's Name/Relationship (Type, Print) MARILYN BLITZ / DAUGHTER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1725 YORK AVENUE #26E - NEW YORK, NY 10128 | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHIZUK AMUNO (ARLINGTON) | | 20c. Location - City or Town, State 11/9/99 BALTIMORE, MD | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee <i>Jay Clayton Lewis</i> | | | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | |
| | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia | | | | Approximate Interval Between Onset and Death 3 days | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Part II: Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Dementia | | | | 23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) 11/8/99 | | | |
| To Be Completed by Physician/Medical Examiner | 28b. Time of Injury M | | | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. | | | |
| | 29b. Signature and title of certifier <i>[Signature]</i> MD | | | | 29c. License number D38675 | | | |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year) 11/8/99 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IDEL MESHULAM 1147 S HANOVER ST BALT MD 21230 | | | |
| | 31. Date filed (Month, Day, Year) NOV 16 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36023

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|---|--|--|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ROBERT LLOYD BURUCKER | | | | 2. Date of Death Month Day Year NOVEMBER 7, 1999 | | 3. Time of Death 10:00 PM | | |
| | 4a. Facility Name (If not institution, give street and number) BRIGHTWOOD ELDERCARE | | | | 4b. City, Town, or Location of Death LUTHERVILLE | | 4c. County of Death BALTIMORE | | |
| Funeral Director | 5. Social Security Number 455-03-3054 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) JUN. 12, 1913 | | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location REISTERSTOWN | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 18 BROOKEBURY DRIVE | | 10f. Zip Code 21136 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) IRON WORKER | | 16b. Kind of Business/Industry STEEL | | 17. Father's Name (First, Middle, Last) HARRY LANGLEY BURUCKER | | 18. Mother's Name (First, Middle, Maiden Surname) ADA MACNEAL | |
| 19a. Informant's Name/Relationship (Type, Print) ROBERT LANGHORNE BURUCKER / SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11960 PARK HEIGHTS AVENUE - OWINGS MILLS 21117 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GARDENS DULANEY VALLEY MEMORIAL | | 20c. Date 11/9/99 | | 20d. Location - City or Town, State TIMONIUM, MD | | | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. aspiration pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 2 days | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) Nov 7, 1999 | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  MD | | 29c. License number 051426 | | 29d. Date signed (Month, Day, Year) Nov. 8, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elliot R. Rothschild, 4000 Old Court, Pikesville, MD 21208 | | 31. Date filed (Month, Day, Year) NOV 16 1999 | | 32. Registrar's Signature  | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36024

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM BOWENS

2. Date of Death
Month Day Year
NOV. 11, 19993. Time of Death
5:30 am

4a. Facility Name (If not institution, give street and number)

MILLENNIUM OF LIBERTY HEIGHTS

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

217-09-5112

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

8. Date of Birth (Month, Day, Year)

08/16/1918

9. Birthplace (State or Foreign Country)

S. Carolina

Usual Residence of Decedent

10e. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3601 Fairview Avenue

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SMELTING

16b. Kind of Business/Industry

Housing Authority

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

Evalyn Western

19e. Informant's Name/Relationship (Type, Print)

Mildred Bowens

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3601 Fairview Avenue, Balto., MD 21216

20e. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Vet. Cem.

Date

11-18-99

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

Willie Howell

22. Name and Address of Facility

Willie E. Howell, Jr.
Howell Funeral Home
4600 Liberty Heights Ave, Balto., MD 21207

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Pneumonia

Due to (or as a consequence of):

b.

chronic asperation

Due to (or as a consequence of):

c.

Cerebro Vascular Accident

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Diabetes

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anil UBEROI MD

29c. License number

D26748

29d. Date signed (Month, Day, Year)

11/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANIL UBEROI 4419 FALLS RD BALTO MD 21211

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36025

| | | | | | | | | |
|---|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WESLEY D. BRANCH | | | | 2. Date of Death Month Day Year November 13 1999 | | 3. Time of Death 5pm | |
| | 4a. Facility Name (If not institution, give street and number) MERCY HOSPITAL - hospice | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 217-80-2496 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 38 Yrs. | | 8. Date of Birth (Month, Day, Year) SEPT. 19, 1961 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 3435 JUNEWAY | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: AFRO-AMERICAN | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11TH | | College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DISHWASHER | | 16b. Kind of Business/Industry FOOD SERVICE | |
| | 17. Father's Name (First, Middle, Last) TOMMIE F. BRANCH | | | | 18. Mother's Name (First, Middle, Maiden Surname) MAUDE SCOTT | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) LAVERNE MC CAFFITY-WARD | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3435 JUNEWAY BALTIMORE, MD. 21213 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS MEM. PARK | | 20c. Location - City or Town, State NOV. 18, 1999 BALTO, MD. | | 20d. Date | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee <i>Bernadine V. Scruggs</i> | | | | 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO, MD. 21213 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Asphyxiation</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>hospice</i> | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 28g. Date of Injury | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>David Rischberg</i> | | 29c. License number D40854 | | 29d. Date signed (Month, Day, Year) 11/19/99 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Rischberg 301 St Paul Pl Baltimore MD 21202 | | | | 31. Date filed (Month, Day, Year) NOV 17 1999 | | | |
| | 32. Registrar's Signature <i>Geneva B. Sparks</i> | | | | 33. Date of Death NOV 13 1999 | | | |

ORIGINAL

1911. 21. The night

1911. 21. The night

1911. 21. The night

1911. 21. The night

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36026

Certificate of Death

Reg. No.

AMEND#16a PER F.H. 6777 11-17-99 J.A.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

ROBERT MERVYN ARMSTRONG

2. Date of Death

Nov 14, 1999

3. Time of Death

4:45 PM

4a. Facility Name (If not institution, give street and number)

GILCHRIST CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE CO.

5. Social Security Number

206-20-3138

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB 16, 1928

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1001 ALICEANNA ST.

10f. Zip Code

21202

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CLERGYMAN

16b. Kind of Business/Industry

CHURCH

17. Father's Name (First, Middle, Last)

RICHARD M. ARMSTRONG

18. Mother's Name (First, Middle, Maiden Surname)

ELVINA E. BOKUS

19a. Informant's Name/Relationship (Type, Print)

PRISCILLA W. ARMSTRONG

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1001 ALICEANNA ST BALTO, MD 21202

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

NOV 15 1999

20c. Location - City or Town, State

BALTO. CO. MD.

21. Signature of Funeral Service Licensee

Thomas J. Skarda Jr.

22. Name and Address of Facility

SKARDA FH 2829 HUDSON ST BALTO, MD 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. prostate cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

W.A. Riley, MD

29c. License number

025205

29d. Date signed (Month, Day, Year)

November 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley, MD 6701 N. Charles St. Balto. MD 21208

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

[Signature]

State Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36027

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|---|---------------------------------|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Kenneth James Buck | | | | 2. Date of Death Month Day Year November 10, 1999 | | 3. Time of Death 4:25 PM | | |
| | 4a. Facility Name (If not institution, give street and number) 616 Delaware Avenue | | | | 4b. City, Town, or Location of Death Essex | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 213-50-8135 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 49 Yrs. | | 8. Date of Birth (Month, Day, Year) March 26, 1950 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 Yes 2 No | | 10e. Street and Number 6510 Kenwood Avenue | | 10f. Zip Code 21237 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: unavailable | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Landscaping | | 16b. Kind of Business/Industry Recreation and Park Service | | | | | |
| 17. Father's Name (First, Middle, Last) Raymond Buck | | | | 18. Mother's Name (First, Middle, Maiden Surname) Evelyn (unavailable) | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Debra Maria Buck (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6510 Kenwood Avenue, Baltimore, Maryland 21237 | | | | | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory | | 20c. Date 11-16-99 | | 20d. Location - City or Town, State Beltsville, Maryland | | | |
| 21. Signature of Funeral Service Licensee Carol A. Del... | | | | 22. Name and Address of Facility CAFA, Stephen D. Lohrmann, P.A. 8717 Green Pastures Drive, Baltimore, MD 21286 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | Immediate Cause (Final disease or condition resulting in death) | | a. Arteriosclerotic Cardiovascular Disease | | Due to (or as a consequence of): | | 10 years | |
| | | | | b. Chronic Obstructive Pulmonary Disease | | Due to (or as a consequence of): | | 5 years | |
| | | | | c. | | Due to (or as a consequence of): | | | |
| | | | | d. | | Due to (or as a consequence of): | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | | | | | | | |
| 24a. Was an autopsy performed? 1 Yes 2 No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | | | | | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | | Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | 26. Place of Death (Check only one) Temporary Residence | | | |
| 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury et Work? 1 Yes 2 No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Philip M. Litello, MD Deputy | | 29c. License number D 18667 | | 29d. Date signed (Month, Day, Year) November 11, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip M. Litello, MD Shock Traumatologist 22 S. Greene St. Baltimore, MD 21201 | | 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature P. Sparks | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ROBERT
BURKHARDTState of Maryland / Department of Health and Mental Hygiene
AMEND ITEMS: #23 PART I, 27, 28A-F, PER MEO, G778 12-3-99 WR. 89 36028
Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Robert Joseph Burkhardt | | | 2. Date of Death Month Day Year NOVEMBER 11, 1999 | | 3. Time of Death 5:30P.M. | | |
| | 4a. Facility Name (If not institution, give street and number) 716 WASHINGTON PLACE | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | | |
| Funeral Director | 5. Social Security Number 213-32-9055 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 64 Yrs. | | 8. Date of Birth (Month, Day, Year) August 28, 1935 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 716 Washington Place | | 10f. Zip Code 21201 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1952-1956 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Merchant Seaman | | 16b. Kind of Business/Industry Shipping | | | | |
| 17. Father's Name (First, Middle, Last) George Anthony Burkhardt | | | | 18. Mother's Name (First, Middle, Maiden Surname) Gertrude Edwards | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Edna Alice Calimer (sister) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6902 Beech Avenue, Baltimore, Maryland 21206 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory | | 20c. Location - City or Town, State 11-15-99 Beltsville, Maryland | | 20d. Date | | |
| 21. Signature of Funeral Service Licensee Carol A. Sch | | 22. Name and Address of Facility CAFA, Stephen D. Lohrmann, P.A. 8717 Green Pastures Drive, Baltimore, MD 21286 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. NARCOTIC INTOXICATION | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? Inspection <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) Found: 11-11-99 | | 28b. Time of Injury Found: 5:25 | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred SUBJECT INGESTED DRUGS | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) 716 WASHINGTON PLACE, BALTIMORE MD | | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | |
| 29b. Signature and title of certifier Stephen S. Radentz | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) NOVEMBER 12, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36029

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Donald N. Beavers

2. Date of Death

Nov

Day

13

Year

1999

3. Time of Death

0130

4a. Facility Name (If not institution, give street and number)

St Agnes Health Care

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

MD

Funeral
Director

5. Social Security Number

214-40-3844

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

05 29

1942

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10e. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

95 Hillside Rd.

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

Collega (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clothing

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Truman Beavers

18. Mother's Name (First, Middle, Maiden Surname)

Audrey (Creamer)

19a. Informant's Name/Relationship (Type, Print)

Patricia Beavers/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

95 Hillside Rd. Catonsville, Md 21228

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place)

Cedar Hill Cemetery

Date

11/16/99

20c. Location - City or Town, State

Brooklyn Park, Md

21. Signature of Funeral Service Licensee

M. G. Marshall

22. Name and Address of Facility

Sterling-Ashton-Schwab Funeral Home Inc.
736 Edmondson Ave. Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Two weeks

3 months

5 years

20 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

P12601

29d. Date signed (Month, Day, Year)

November 13 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 Caton Ave Baltimore, MD 21229 Todd C. Rau

State
Registrar

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

NAME DONALD BEAVERS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

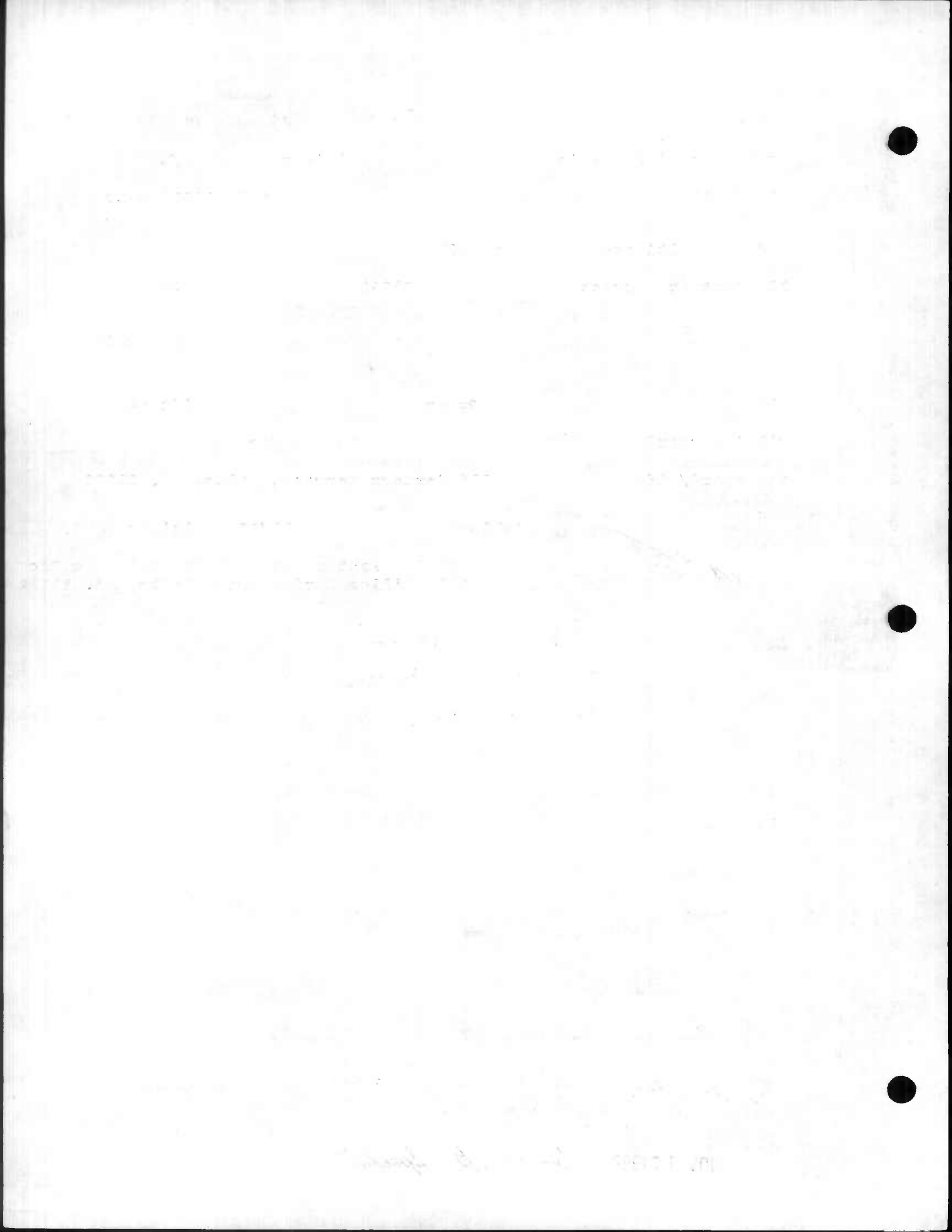
State of Maryland / Department of Health and Mental Hygiene 99 36030

Certificate of Death

Reg. No.

| | | | | | |
|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Joseph Byard</u> | | 2. Date of Death Month <u>November</u> Day <u>10</u> Year <u>1999</u> | | 3. Time of Death <u>0707</u> |
| | 4a. Facility Name (If not institution, give street and number) <u>Johns Hopkins Bayview</u> | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | 4c. County of Death <u>N/A</u> |
| Funeral Director | 5. Social Security Number <u>213-54-3196</u> | 6. Sex <u>1</u> M <u>2</u> F | 7. Age (In yrs. last birthday) <u>48</u> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) <u>03 19 1951</u> | | 9. Birthplace (State or Foreign Country) <u>MD</u> | | |
| Usual Residence of Decedent | | | | | |
| 10a. State <u>MD</u> | | 10b. County <u>Baltimore</u> | | 10c. City, Town or Location <u>Dundalk</u> | |
| 10d. Inside City Limits <u>1</u> Yes <u>2</u> No | | | | | |
| 10e. Street and Number <u>115 Ventnor Terrace</u> | | | 10f. Zip Code <u>21222</u> | | 10g. Citizen of What Country? <u>USA</u> |
| 11. Marital Status <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: <u>White</u> | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10</u> College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Owner</u> | | 16b. Kind of Business/Industry <u>Gift Shop</u> | |
| 17. Father's Name (First, Middle, Last) <u>William Byard</u> | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Ruth Noyes</u> | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>Pam Byard/wife</u> | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>115 Ventnor Terrace, Balto, Md. 21222</u> | | |
| 20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Oaklawn</u> | | Date <u>11/13</u> | 20c. Location - City or Town, State <u>Baltimore, Md.</u> |
| 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility <u>Bradley Ashton Matthews Funeral Home Inc</u> <u>2134 Willow Spring Road, Balto, MD 21222</u> | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | | | | |
| a. <u>Cardiogenic Shock</u> Due to (or as a consequence of): | | | | | |
| b. <u>Myocardial Infarction</u> Due to (or as a consequence of): | | | | | |
| c. <u>Coronary Artery Atherosclerosis</u> Due to (or as a consequence of): | | | | | |
| d. | | | | | |
| 23b. Approximate Interval Between Onset and Death <u>12 hours</u> | | | | | |
| 23c. Approximate Interval Between Onset and Death <u>12 hours</u> | | | | | |
| 23d. Approximate Interval Between Onset and Death <u>10 years</u> | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Pulmonary edema</u> | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown | | | | | |
| 24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No | | | | | |
| 25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No | | 26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) | | | |
| 27. Manner of Death <u>1</u> Natural <u>5</u> Pending investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <u>M</u> | |
| 28c. Injury at Work? <u>1</u> Yes <u>2</u> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number <u>RES-000</u> | | 29d. Date signed (Month, Day, Year) <u>November 10, 1999</u> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>600 North Wolfe Street, Tower 110, Baltimore, Maryland 21205</u> | | | | | |
| 31. Date filed (Month, Day, Year) <u>NOV 17 1999</u> | | 32. Registrar's Signature | | | |

ORIGINAL



ADH
UNKNOWN 99-275
99-6802-510
GEORGE CARTER JR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36031

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | |
|--|---|---|---|----------------------------------|--|---|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GEORGE ISAC CARTER, JR. | | | | | | 2. Date of Death Month Day Year NOVEMBER 13, 1999 | | 3. Time of Death 1521 PM | | | | |
| | 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A | | | | | | |
| Funeral Director | 5. Social Security Number 214 98 7343 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 17 Yrs. | | 8. Date of Birth (Month, Day, Year) 11-16-1981 | | 9. Birthplace (State or Foreign Country) MARYLAND | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD. | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 10e. Street and Number 3929 BELLE AVENUE | | | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? U.S. OF A. | | | | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (1-4 or 5+) UNKNOWN | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STUDENT | | | 16b. Kind of Business/Industry PUBLIC SCHOOL | | | | | |
| | 17. Father's Name (First, Middle, Last) GEORGE ISAC CARTER, SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname) PURLINE JOHNSON CARTER | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) GEORGE I. CARTER, SR. (FATHER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3929 BELLE AVENUE BALTIMORE, MD. 21215 | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) VOSHELL MEMORIAL GARDENS | | | | Date 11/20/99 | | 20c. Location - City or Town, State BALTIMORE, MARYLAND | | | | |
| | 21. Signature of Funeral Service Licensee Lewis T. Gwynn | | | | 22. Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVENUE BALTO., MD. | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Blunt Force Trauma with complications Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 10-26-99 | | 28b. Time of Injury 18:30 P M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Suspect was struck. | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Maurice Jones | | | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) NOVEMBER 14, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. K. Sparks P. K. Sparks 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 17 1999 | | | | 32. Registrar's Signature H. K. Sparks | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36032

| | | | | | | | | | |
|--|--|---|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ROSE CASSELL | | | | 2. Date of Death Month Day Year NOV. 12 1999 | | 3. Time of Death 7PM | | |
| | 4a. Facility Name (If not institution, give street and number) 7 POMONA WEST APT. 11 | | | | 4b. City, Town, or Location of Death PIKESVILLE | | 4c. County of Death BALTIMORE | | |
| Funeral Director | 5. Social Security Number 215-16-1341 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) 11 24 1919 | | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location PIKESVILLE | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 7 POMONA WEST APT. 11 | | 10f. Zip Code 21208 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERK | | 16b. Kind of Business/Industry STATE OF MD. | | | | | |
| 17. Father's Name (First, Middle, Last) MORRIS EVNITZ | | | | 18. Mother's Name (First, Middle, Maiden Surname) DORA BARTZ | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) JERRY EVNITZ/NEPHEW | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 ESTATES COURT #5205 BALTO. MD. 21208 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHURCH AMUNO 11/15/ ARLINGTON CONGREGATION 99 BALTO. MD. | | 20c. Location - City or Town, State | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN RD. PIKESVILLE MD 21208 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Probable Ventricular Tachycardia fibrillation Due to (or as a consequence of): b. Left Ventricular Dysfunction / Myocardial Ischemia Due to (or as a consequence of): c. Past Myocardial Infarction Due to (or as a consequence of): d. Severe Ischemic Heart Disease | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number D 18538 | | 29d. Date signed (Month, Day, Year) 11.13.99 | | | |
| 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) Joseph SaGhmon M.D., 8600 Liberty Rd, Baltimore, Md, 21133 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36033

Amend Item#19a perHF G777 11/17/99 EW

Certificate of Death

Reg. No.

| | | | | | | |
|--|---|--|--|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LOUIS CAPLAN | | 2. Date of Death Month Day Year NOVEMBER 13, 1999 | | 3. Time of Death 8:00 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) VAMHCS, FORT HOWARD DIVISION | | 4b. City, Town, or Location of Death FORT HOWARD | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 217-03-3980 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 93 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JUNE 4 1906 |
| | 9. Birthplace (State or Foreign Country) RUSSIA | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location ROSEDALE | |
| | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| | 10e. Street and Number 2214 HAMILTOWNE CIRCLE | | 10f. Zip Code 21237 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WW II If Yes, Give Year or Dates: ARMY | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DISTRIBUTOR | | 16b. Kind of Business/Industry NEWSPAPER | |
| | 17. Father's Name (First, Middle, Last) SAMUEL CAPLAN | | 18. Mother's Name (First, Middle, Maiden Surname) IDA SIRKIS | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Wayne HENRY CAPLAN/NEPHEW | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5380 IRVING RUBY RD. SYKESVILLE, MD. 21784 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MD.FREE STATE POST 167 | | 20c. Location - City or Town, State ROSEDALE, MD. | |
| | 21. Signature of Funeral Service Licensee <i>Jay Allan Lewis</i> | | 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD. 21208 | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. COLON CANCER Due to (or as a consequence of): CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | |
| 29b. Signature and title of certifier <i>L. Shuk</i> | | 29c. License number 052739 | | 29d. Date signed (Month, Day, Year) Nov. 13, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. SURESH SHANDELYA, M.D., 9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052 | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36034

| | | | | | | | | |
|---|--|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Barbara Rhona Crowther | | | | 2. Date of Death Month NOV Day 15 Year 99 | | 3. Time of Death 10:05 PM | |
| | 4a. Facility Name (If not institution, give street and number) Union Memorial Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 219-26-7227 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 61 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Feb. 18, 1938 | 9. Birthplace (State or Foreign Country) Maryland |
| | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 3832 Elm Avenue | | 10f. Zip Code 21211 | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry In Own Home | | | | |
| 17. Father's Name (First, Middle, Last) Keener Benjamin Albaugh | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Emma Jenkins | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Rolan G. Crowther Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3832 Elm Avenue Baltimore, Maryland 21211 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn Memorial Grdn | | Date 11/19/99 | | 20c. Location - City or Town, State Marriottsville, MD | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) a. STEATOHEPATITIS Due to (or as a consequence of): | | | | | | | | 2 MONTHS |
| b. PNEUMONIA Due to (or as a consequence of): | | | | | | | | 1 MONTH |
| c. Due to (or as a consequence of): | | | | | | | | |
| d. Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number AT-2438946 | | 29d. Date signed (Month, Day, Year) NOV 15, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANGLA GULATI UNION MEMORIAL HOSP. 201 E. UNIVERSITY PKWY BALTIMORE, MD 21218 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

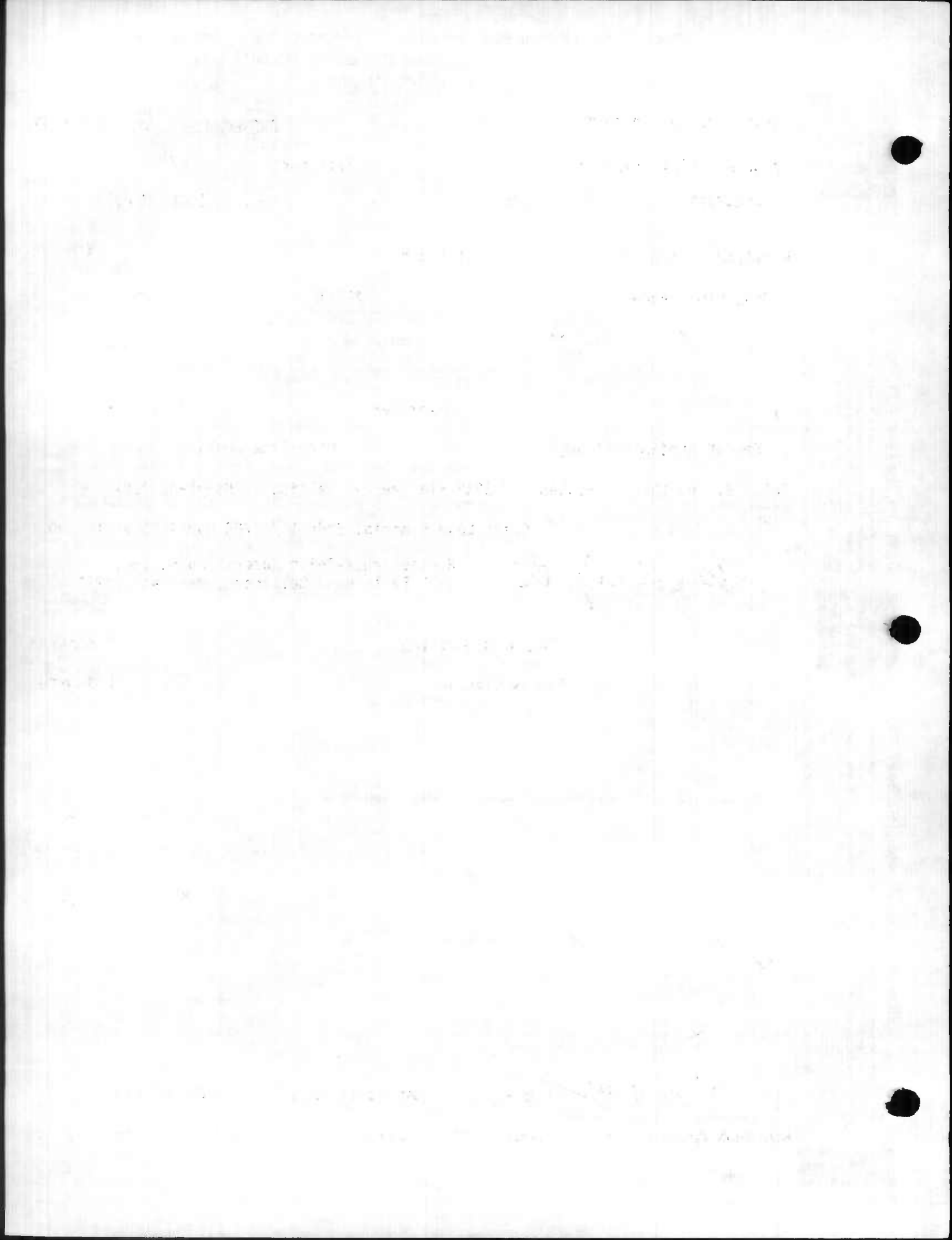
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36035

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|--|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARJORIE H. COLLINS | | | | 2. Date of Death Month 11 Day 15 Year 1999 | | 3. Time of Death 5:30 AM | | |
| | 4e. Facility Name (If not institution, give street and number) KESWICK | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 220-12-4884 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 89 Yrs. | | 8. Date of Birth (Month, Day, Year) 04-10-1910 | | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10e. State MD. | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE CITY | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10f. Zip Code 21211 | | 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | |
| | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS College (1-4or 5+) COLLEGE | | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER | | 16b. Kind of Business/Industry EDUCATION | | 17. Father's Name (First, Middle, Last) AQUILLA BROWN HANSON | | 18. Mother's Name (First, Middle, Maiden Surname) ELEANOR WILLIAMS | | |
| | 19e. Informant's Name/Relationship (Type, Print) SANDRA H. HARGRAVE (NIECE) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7901 CROSMOORE LANE, TOWSON, MARYLAND, 21204 | | | | | | |
| To Be Completed by Physician/Medical Examiner | 20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GREEN MOUNT CREMATORY | | Date 11-16 | | 20c. Location - City or Town, State BALTO., MD., 21202 | | |
| | 21. Signature of Funeral Service Licensee R. G. Reith | | 22. Name and Address of Facility HENRY W. JENKINS AND SONS COMPANY 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 | | | | | | |
| Physician /Medical Examiner | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCVD Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Senile Dementia Ovarian mass | | | | | | | Approximate Interval Between Onset and Death YEARS | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Senile Dementia Ovarian mass | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Dr. J. J. Jones MD | | 29c. License number D16619 | | 29d. Date signed (Month, Day, Year) 11/15/99 | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) C. VERGARA - SPARES 700 W. 40th STREET BALTIMORE, MD. 21211 | | | | | | | 31. Date filed (Month, Day, Year) NOV 17 1999 | |
| State Registrar | 32. Registrar's Signature James B. Sparks | | 33. Date of Death (Month, Day, Year) NOV 15 1999 | | | | | | |
| | 34. Date of Death (Month, Day, Year) NOV 15 1999 | | 35. Date of Death (Month, Day, Year) NOV 15 1999 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36036

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lillian Cohen

2. Date of Death

November 11 99

3. Time of Death

9:30 p.m.

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

056-52-1036

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12 02 1906

9. Birthplace (State or Foreign Country)

England

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5154 Phantom Ct

10f. Zip Code

21044

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Solomon Borsook

18. Mother's Name (First, Middle, Maiden Surname)

Hilda Unknown

19a. Informant's Name/Relationship (Type, Print)

Adele Grossman/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

82 Susan Dr. Newburgh NY 12550

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mt. Hebron

Date

11/14

20c. Location - City or Town, State

Flushing, NY

21. Signature of Funeral Service Licensee

Mgt. Munday

22. Name and Address of Facility

Sterling Ashton Schwab Funeral Home Inc

736 Edmondson Avenue Balto. MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Myocardial infarction
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Coronary artery disease
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mgt. Munday

29c. License number

D50976

29d. Date signed (Month, Day, Year)

11/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven H. Eversley MD 4801 Darsen Hall Drive Ellicott City

State
Registrar

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Certificate of Death

Reg. No.

AMENDED ITEM #20b PER FH G778 12/27/99 AH

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

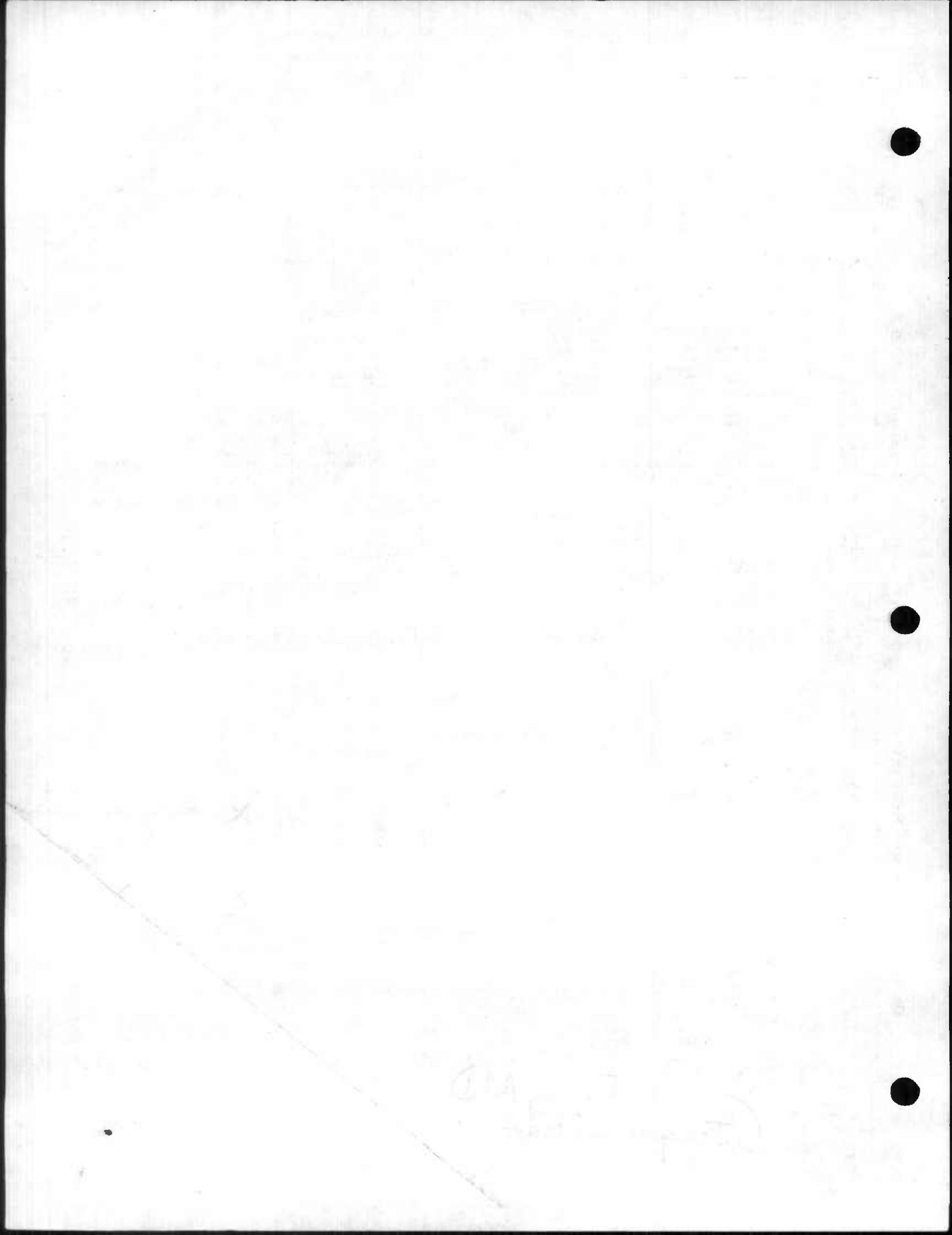
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | | | |
|--|--|------------------------|---|---|---|--------------------------------------|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Norman Carmo | | | | 2. Date of Death Month Day Year NOVEMBER 14 1999 | | | | 3. Time of Death 8:39 P | | |
| | 4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL | | | | 4b. City, Town, or Location of Death RANDALSTOWN | | | | 4c. County of Death BALTIMORE | | |
| Funeral Director | 5. Social Security Number 172 34 2103 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 58 Yrs. | | 8. Date of Birth (Month, Day, Year) 10.17.1941 | | 9. Birthplace (State or Foreign Country) West VA | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State PA | | 10b. County Indiana | | 10c. City, Town or Location Blairsville | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 336 First Avenue. | | | | 10f. Zip Code 15717 | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter | | | | 16b. Kind of Business/Industry Machine Manufacturing | | | |
| 17. Father's Name (First, Middle, Last) Walter Carmo, SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Reba Spangler | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Linda Carmo/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 336 First Ave. Blairsville, PA 15717 | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Blairsville Cemetery | | Date 11/19/99 | | 20c. Location - City or Town, State Blairsville, PA | | | | |
| 21. Signature of Funeral Service Licensee Mark Marshall | | | | 22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home Inc. 736 Edmondson Ave. Catonsville, MD 21228 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Atherosclerotic cardiovascular disease</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier Joseph Pestaner MD | | | | 29c. License number O.C.M.E | | | | 29d. Date signed (Month, Day, Year) NOVEMBER 15, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | | |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36038

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | |
|---|---|--|---|---|--|---|------------------|----------------------------------|---|-----------------------------------|----------------------------------|----|----------------------------------|----|----------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>SALLIE DAVIS</i> | | 2. Date of Death Month: <i>NOVEMBER</i> Day: <i>14</i> Year: <i>1999</i> | | 3. Time of Death <i>11:40pm</i> | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) <i>Johns Hopkins Bayview Medical Center</i> | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | 4c. County of Death <i>NA</i> | | | | | | | | | | |
| Funeral Director | 5. Social Security Number <i>081-14-3607</i> | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>94</i> Yrs. | 8. Date of Birth Month: <i>04</i> Day: <i>14</i> Year: <i>05</i> | 9. Birthplace (State or Foreign Country) <i>NC</i> | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State <i>MD</i> | 10b. County <i>NA</i> | 10c. City, Town or Location <i>Baltimore</i> | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| | 10e. Street and Number <i>111 Chestnut Street</i> | | 10f. Zip Code <i>21222</i> | | 10g. Citizen of What Country? <i>USA</i> | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | | | | | | | |
| | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10th Grade</i> College (1-4 or 5+) <i>NA</i> | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Seamstress</i> | | 16b. Kind of Business/Industry <i>Company</i> | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) <i>Harrison Faulcon</i> | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Nettie Byrd</i> | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <i>Elaine Gill</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1007 Andover Road Baltimore, Maryland 21218</i> | | | | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Arbutus Mem. Pk. Cem.</i> | | 20c. Location - City or Town, State <i>11-18-99 Arbutus, MD.</i> | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee <i>Bernard P. Johnson</i> | | 22. Name and Address of Facility <i>Baltimore, Maryland 21202</i> <i>WM.C. March FH 1101 E. North Avenue</i> | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>e. <i>SEPSIS</i></td> <td>Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death <i>THREE DAYS</i></td> </tr> <tr> <td>b. <i>URINARY TRACT INFECTION</i></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table> | | | | | | Immediate Cause (Final disease or condition resulting in death) | e. <i>SEPSIS</i> | Due to (or as a consequence of): | Approximate Interval Between Onset and Death <i>THREE DAYS</i> | b. <i>URINARY TRACT INFECTION</i> | Due to (or as a consequence of): | c. | Due to (or as a consequence of): | d. | Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death) | e. <i>SEPSIS</i> | Due to (or as a consequence of): | Approximate Interval Between Onset and Death <i>THREE DAYS</i> | | | | | | | | | | | | |
| | b. <i>URINARY TRACT INFECTION</i> | Due to (or as a consequence of): | | | | | | | | | | | | | |
| | c. | Due to (or as a consequence of): | | | | | | | | | | | | | |
| | d. | Due to (or as a consequence of): | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | | | | | | | | | | | |
| 28a. Date of Injury (Month, Day Year) | | | | | | | | | | | | | | | |
| 28b. Time of Injury <i>M</i> | | | | | | | | | | | | | | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| 28d. Describe how injury occurred | | | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Scott Ziff MD</i> | | | | | | | | | | | | | | | |
| 29c. License number <i>98035</i> | | | | | | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year) <i>NOVEMBER 17, 1999</i> | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Scott Ziff MD Johns Hopkins Bayview Medical Center Baltimore, MD, 21224</i> | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>NOV 17 1999</i> | | | | | | | | | | | | | | | |
| 32. Registrar's Signature <i>Spencer</i> | | | | | | | | | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

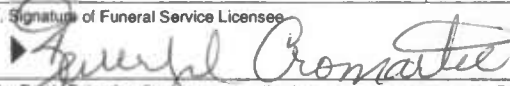
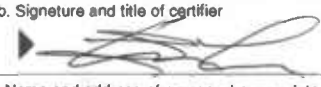
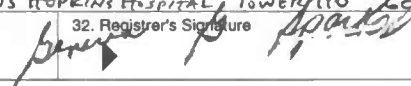
State of Maryland / Department of Health and Mental Hygiene

99 36039

Amended Item#5 per Inf G778 12/01/99 EW

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MERTIERAN | | | | 2. Date of Death Month Day Year NOVEMBER 12 1999 | | | | 3. Time of Death 7:10 AM | |
| | 4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 217-34-3845 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 59 Yrs. | | 8. Date of Birth (Month/Day/Year) 4/1/40 | | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 4034 Hillen Rd. | | | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bus Driver | | | | 16b. Kind of Business/Industry MTA | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) John Dozier | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marie Perry | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) ERIC DOZIER (son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4034 Hillen Rd. Baltimore, Maryland 21213 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery | | Date 11/18/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Betts Funeral Home 1129 N. Caroline St. Baltimore, MD 21213 | | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death | |
| | Immediate Cause (Final disease or condition resulting in death) a. HODGKIN'S DISEASE Due to (or as a consequence of): | | | | | | | | 7 MONTHS | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. SEPSIS Due to (or as a consequence of): | | | | | | | | 6 DAYS | |
| | c. Due to (or as a consequence of): | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier  INTERIM | | | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) NOVEMBER 12, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHUAIB LATIF JOHNS HOPKINS HOSPITAL TOWER 110 600 NORTH WOLFE STREET BALTIMORE MD 21287 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 17 1999 | | | | 32. Registrar's Signature  | | | | | |
| | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36040

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) BERNARD DAVIES | | 2. Date of Death Month NOVEMBER Day 11 Year 1999 | | 3. Time of Death 6:00 PM | |
| 4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER | | | 4b. City, Town, or Location of Death RANDALLSTOWN | | 4c. County of Death BALTIMORE |
| 5. Social Security Number 218-28-6510 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 83 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| 8. Date of Birth (Month, Day, Year) APR. 3, 1916 | | 9. Birthplace (State or Foreign Country) ENGLAND | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location BALTIMORE | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 16 OLD COURT ROAD #612 | | | 10f. Zip Code 21208 | | 10g. Citizen of What Country? U.S.A. |
| 11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES | | 16b. Kind of Business/Industry HOME APPLIANCES | |
| 17. Father's Name (First, Middle, Last) MICHAEL DAVIES | | | 18. Mother's Name (First, Middle, Maiden Surname) SARAH GOODMAN | | |
| 19a. Informant's Name/Relationship (Type, Print) BETTY DAVIES / WIFE | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 OLD COURT ROAD #612 - BALTIMORE, MD 21208 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) HAR SINAI CEMETERY | | 20c. Location - City or Town, State 11/14/99 OWINGS MILLS, MD | |
| 21. Signature of Funeral Service Licensed  | | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) a. POST-OP MI Due to (or as a consequence of): b. SEPSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. BOWEL OBSTRUCTION | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number 244505 | | 29d. Date signed (Month, Day, Year) NOVEMBER 11, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. J. INTERIM, Jr. NW 42 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature  | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36041

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Harry Henschen DepKin

2. Date of Death

Month Day Year
November 12, 1999

3. Time of Death

8:28 pm

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-03-1450

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 21, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3336 Willoughby Road

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

—

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Foreman

16b. Kind of Business/Industry

French-Bray Printing Co.

17. Father's Name (First, Middle, Last)

Harry Edward DepKin

18. Mother's Name (First, Middle, Maiden Surname)

Hilda Henschen

19a. Informant's Name/Relationship (Type, Print)

Hilda E. Rosenberger-daugh.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

41 Perry Oak Place Baltimore, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

Date

Nov. 16, 1999

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Heather Cain

22. Name and Address of Facility

Evans Chapel of Memories
8800 Harford Road
Baltimore, Maryland 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic carcinoma of unknown primary site

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anthony Riley, MD

29c. License number

025205

29d. Date signed (Month, Day, Year)

November 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley GBMC 6701 N. Charles St. Balto md 21208

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

Berna Sparks

State
Registrar

Depkin, Harry November 12, 1999 8:28 pm
Baltimore, Maryland 21235-0020

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7333.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36042

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|---|--|--|--|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HELEN S. DAVIS | | | | 2. Date of Death Month Day Year NOVEMBER 13, 1999 | | | | 3. Time of Death 0535 AM | | |
| | 4a. Facility Name (If not institution, give street and number) ROUTE 40 EAST 1/2 MILE WEST OF ABINGDON ROAD | | | | 4b. City, Town, or Location of Death ABINGDON | | | | 4c. County of Death HARFORD | | |
| Funeral Director | 5. Social Security Number 212-34-2206 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 65 Yrs. | | 8. Date of Birth (Month, Day, Year) 12-21-33 | | 9. Birthplace (State or Foreign Country) MD | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County HARFORD | | 10c. City, Town or Location EDGEWOOD | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 1300 CLOVER VALLEY | | | | 10f. Zip Code 21040 | | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH GRADE College (14 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MTA DRIVER | | | | 16b. Kind of Business/Industry TRANSPORTATION | | | |
| 17. Father's Name (First, Middle, Last) JOHN CONNOR | | | | 18. Mother's Name (First, Middle, Maiden Surname) HELEN BOWMAN | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) JAMES STILLS SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2327 AIKEN ST., BALTO. MD. 21218 | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) EBERNEZER BAPTIST CHURCH CEMETERY | | Date 11-18-99 | | 20c. Location - City or Town, State JOPPA, MD | | | |
| 21. Signature of Funeral Service Licensee Vaughn C. Greene | | | | 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple tumors Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) 11-13-99 | | 28b. Time of Injury 0432A M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred. VEHICLE(S) PASSENGER IN CAR, IN COLLISION WITH | | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ROADSIDE | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) RT 40 EAST 1/2 MILE W. OF ABINGDON RD HARFORD CO MD | | | | | | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier Maureen D. McKelvey MD | | | | 29c. License number O.C.M.E. | | | | 29d. Date signed (Month, Day, Year) NOVEMBER 13, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARJORIE P. WILSON 11 PENN STREET BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | | | 32. Registrar's Signature Geneva B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36043

Certificate of Death

Reg. No.

AMENDED ITEM #8 PER FH G778 12/27/99 AH

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|---|--|---|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) James Gordon Ebaugh | | | | 2. Date of Death Month Nov. Day 14, Year 1999 | | 3. Time of Death 1 PM | |
| 4a. Facility Name (If not institution, give street and number) 3907 Roland Avenue | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| 5. Social Security Number 216-28-0484 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 66 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 11-UNK -1932 | 9. Birthplace (State or Foreign Country) Baltimore, MD |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 3907 Roland Avenue | | | | 10f. Zip Code 21211 | | 10g. Citizen of What Country? U.S.A | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korea | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) College | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inventory Controller | | 16b. Kind of Business/Industry American Standard | |
| 17. Father's Name (First, Middle, Last) Ebaugh | | | | 18. Mother's Name (First, Middle, Maiden Surname) Gertrude Hetherington | | | |
| 19a. Informant's Name/Relationship (Type, Print) Herbert S. Steinberg Friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Quimper Ct. Apt. 3A Baltimore, MD 21208-3070 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Balto-Washington Crematory | | Date 11/16/99 | | 20c. Location - City or Town, State Laurel, Maryland | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Burgess-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211 | | | |
| 23. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | | | | | | |
| a. LUNG CANCER Due to (or as a consequence of): | | | | | | | |
| b. COPD Due to (or as a consequence of): | | | | | | | |
| c. Due to (or as a consequence of): | | | | | | | |
| d. Due to (or as a consequence of): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number 044944 | | 29d. Date signed (Month, Day, Year) 11/16/99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Stanley Walker 3333 North Calvert Street Baltimore Maryland 21227 | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | | | 32. Registrar's Signature | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Handwritten text in Arabic script, appearing as bleed-through from the reverse side of the page. The text is faint and mostly illegible due to the quality of the scan and the nature of the bleed-through.

Handwritten text in Arabic script, appearing as bleed-through from the reverse side of the page. The text is faint and mostly illegible due to the quality of the scan and the nature of the bleed-through.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36044

AMENDED ITEM # 13 PER FH G778 12/27/99 AH

Physician
/Medical
Examiner

1. Decedant's Name (First, Middle, Last)

ELLEN LUCINDA EPPS

2. Date of Death

November 12, 1999 10:42 AM

3. Time of Death

N/A

4a. Facility Name (If not institution, give street and number)

BON SECOURS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-22-4966

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APRIL 04, 1919 SOUTH CAROLINA

9. Birthplace (State or Foreign Country)

SOUTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2312 CHELSEA TERRACE

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8TH GRADE

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OFFICE ASSISTANT

16b. Kind of Business/Industry

FOREST PARK SENIOR CENTER

17. Father's Name (First, Middle, Last)

JAMES

18. Mother's Name (First, Middle, Maiden Surname)

ALMENA

FOX

19a. Informant's Name/Relationship (Type, Print)

ROSLYN EPPS (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2312 CHELSEA TERRACE, BALTIMORE, MD. 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUTUS CEMETERY

Date

11-18-99

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE. BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes
Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

MD0029968

29d. Date signed (Month, Day, Year)

November 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. John Adams 15121 WATERGATE RD Silver Spring Md 20905

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

[Signature]

State Registrar

DHM 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

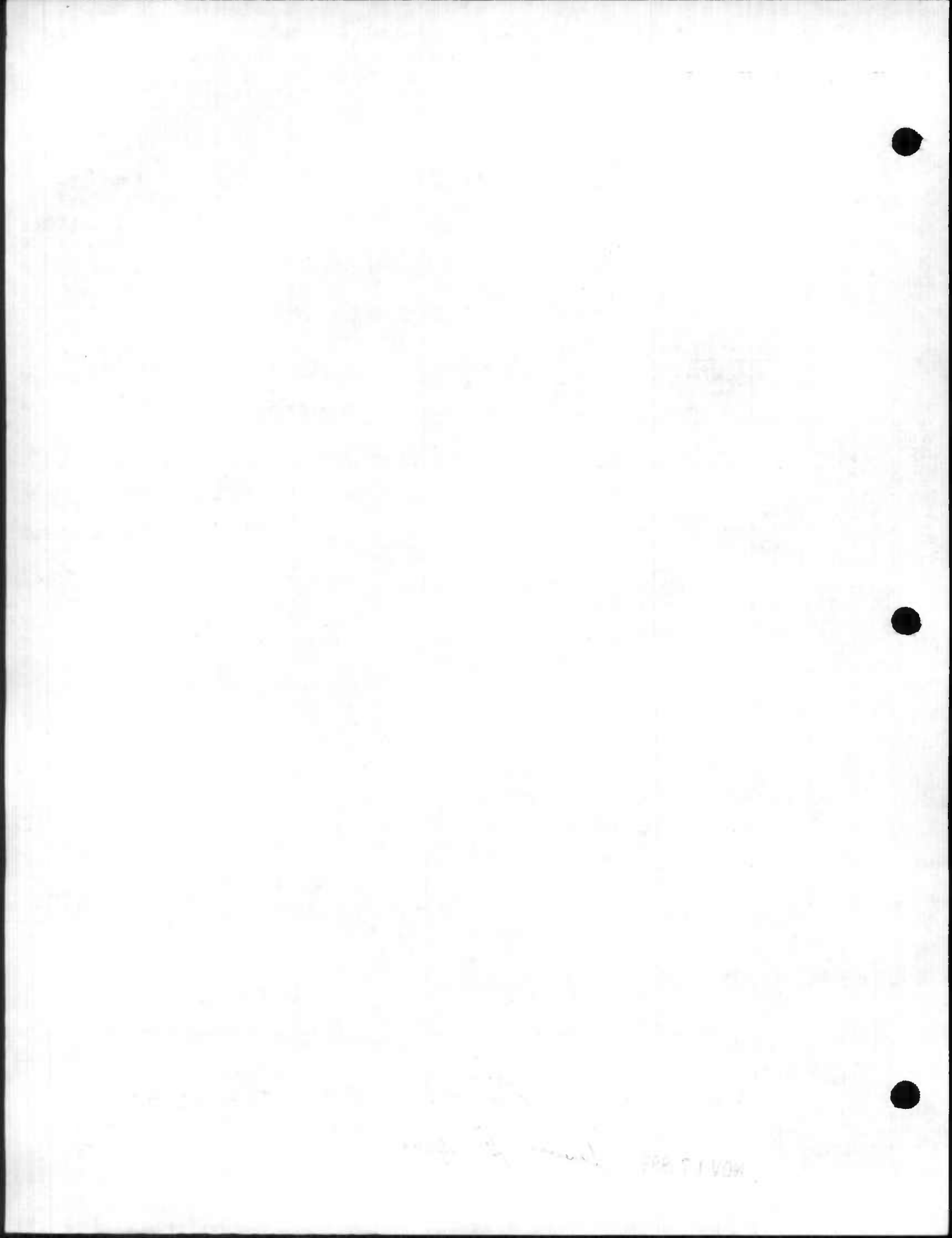
Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Ellen Epps

AH



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36045**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Katherine M. Foertsch

2. Date of Death
Month Day Year
NOVEMBER 4, 1999
3. Time of Death
9:11AM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-07-8039

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct 31, 1917

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9640 Dixon Avenue

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

JOSEPH J. Doyle

18. Mother's Name (First, Middle, Maiden Summa)

Elizabeth Laurer

19a. Informant's Name/Relationship (Type, Print)

Joseph F. Foertsch/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9640 Dixon Ave, Baltimore, MD 21234

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State
☒ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

RESPIRATORY FAILURE

Approximate Interval Between Onset and Death

DAYS

a. Due to (or as a consequence of):

PNEUMONIA

DAYS

b. Due to (or as a consequence of):

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient ☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Suicida
☐ Homicida ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28i. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Richard L. Linthicum

29c. License number

D31826

29d. Date signed (Month, Day, Year)

11-4-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD L. LINTHICUM M.D. 7601 OSLER DRIVE TOWSON, MD. 21204

State
Registrar

31. Date filed (Month, Day, Year)

NOV 15 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

NOV 12 1953

James H. Jones

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36046

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Paul F. Fox, Sr.

2. Date of Death

NOVEMBER 15, 1999

3. Time of Death

3:08 AM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

220-05-4736

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 14 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7909 Tilmont Ave.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

—

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

self-employed - owner

16b. Kind of Business/Industry

Clifton upholstery com.

17. Father's Name (First, Middle, Last)

Jeremiah A. Fox

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth K. Manzke

19a. Informant's Name/Relationship (Type, Print)

Clementine Fox - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7909 Tilmont Ave. Baltimore Md 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cemetery

Date

Nov 18 1999

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Krista S. Wells

22. Name and Address of Facility

Evans Funeral Chapel
8800 Harford Rd. Baltimore, Md 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PNEUMONIA

a. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

SEPSIS

b. Due to (or as a consequence of):

2 DAYS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

M

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier
guy... P. Mehta M.D.
29c. License number
D 0041410
29d. Date signed (Month, Day, Year)
November 15th, 1999.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER P. MEHTA, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

Nov. 17 1999

32. Registrar's Signature

R. Sparks

State
Registrar

ORIGINAL

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Fax, Paul

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36047

AMENDED ITEM #8 PER FH G777 11/17/99 AH

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Richard M. Freeze

2. Date of Death

Nov 12 1999

3. Time of Death

11:25AM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-84-6683

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

39 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 16, 1960

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10337 Malcolm Circle

10f. Zip Code

21030

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Shipping Supt.

16b. Kind of Business/Industry

Super Fresh

17. Father's Name (First, Middle, Last)

Richard T. Freeze

18. Mother's Name (First, Middle, Maiden Surname)

Carollee McCreedy

19a. Informant's Name/Relationship (Type, Print)

Michael W. Stifler

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10337 Malcolm Circle Cockeysville, Md 21030

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery

Date

Nov 15 1999

20c. Location - City or Town, State

Baltimore Maryland

21. Signature of Funeral Service Licensee

Heide S. Wells

22. Name and Address of Facility

Evans Funeral Chapel
8800 Hartford Rd. Baltimore, Md 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acquired Immune Deficiency Syndrome

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Tariq =

29c. License number

D43725

29d. Date signed (Month, Day, Year)

11/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State
Registrar

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

Benjamin B Sparks

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RICHARD FREEZE November 12, 1999 11:25 a.m.

John C. Smith

Nov 13 1994

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36048

| | | | | | | | | |
|---|--|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Jerome Kent Fleming | | | | 2. Date of Death Month Day Year November 15, 1999 | | 3. Time of Death 7:45 am | |
| | 4a. Facility Name (If not institution, give street and number) 13613 Creekside Drive | | | | 4b. City, Town, or Location of Death Silver Spring, MD | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 143-22-0098 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 Yrs. | | 8. Date of Birth (Month, Day, Year) January 7, 1931 | |
| | 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring Maryland | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 13613 Creekside Drive | | 10f. Zip Code 20904 | | 10g. Citizen of What Country? United States | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Unk. | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Divisional Staff Manager | | 16b. Kind of Business/Industry Communications | | | | |
| 17. Father's Name (First, Middle, Last) Pliny E. Fleming | | | | 18. Mother's Name (First, Middle, Maiden Surname) Virginia Adkins | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Barbara Fleming / Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13613 Creekside Drive, Silver Spring Maryland 20904 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Fairview Cemetery | | Date November 19, 1999 | | 20c. Location - City or Town, State Cape May Courthouse, NJ | | |
| 21. Signature of Funeral Service Licensee Victor P. Doda, Jr.  | | | | 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Uremia Due to (or as a consequence of): b. Diabetes Mellitus Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death 3 Weeks Years | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Merked Cell Tumor | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and Title of certifier  | | | | | | |
| | | 29c. License number D-20400 | | 29d. Date signed (Month, Day, Year) November 15, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark S. Rosen, M.D., 39411 Ferrara Drive, Wheaton Maryland 20906 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature  | | | | | | |

ORIGINAL

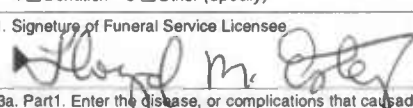
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36049

| | | | | | | | | | | |
|---|--|---|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARY C. FOSTER | | | | 2. Date of Death Month Day Year NOVEMBER 9, 1999 | | | | 3. Time of Death 6:50 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) MARINER HEALTHCARE OF GLEN BURNIE | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | | | 4c. County of Death ANNIE ARUNDEL, CO. | |
| Funeral Director | 5. Social Security Number 156-12-3664 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 87 Yrs. | | 8. Date of Birth (Month, Day, Year) AUG 8, 1912 | | 9. Birthplace (State or Foreign Country) ALABAMA | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MARYLAND | | 10b. County BALTIMORE | | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number 2303 LYNTHURST AVE. | | 10f. Zip Code 21216 | | 10g. Citizen of What Country? USA | | | | | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: AFRO. AMERICAN | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSE | | | | 16b. Kind of Business/Industry HOSPITAL | | |
| 17. Father's Name (First, Middle, Last) JIM FOSTER | | | | 18. Mother's Name (First, Middle, Maiden Surname) LESLIE FOSTER | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) DIMETRA FOSTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2303 LYNTHURST AVE, BALTIMORE, MARYLAND 21216-2014 | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY, INC. | | Date 11/11/99 | | 20c. Location - City or Town, State CATONSVILLE, MD. | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility ESTEP BROTHERS FUNERAL, P. A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sick Sinus Syndrome Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death 4 yrs 2 yrs | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number D40519 | | 29d. Date signed (Month, Day, Year) 11-10-99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miguel M. Nolasco, 7845 Oakwood Professional Bldg, Suite 200, Glen Burnie | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature  | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36050

| | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HAROLD K. GOLDMAN | | | | 2. Date of Death Month Day Year NOVEMBER 13, 1999 | | 3. Time of Death 10:45 AM | | |
| | 4a. Facility Name (If not institution, give street and number) PIKESVILLE NURSING HOME | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE | | |
| Funeral Director | 5. Social Security Number 215-10-1813 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) DEC. 28, 1913 | | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country) MD | | 10. State MD | | 10a. County N/A | | |
| 10b. City, Town or Location BALTIMORE | | 10c. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10d. Street and Number 3631 GLENGYLE AVENUE #A-6 | | 10e. Zip Code 21215 | | 10f. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PHARMACIST | | 16b. Kind of Business/Industry PHARMACY | | 17. Father's Name (First, Middle, Last) ABRAHAM GOLDMAN | | 18. Mother's Name (First, Middle, Maiden Surname) ESTHER SONNER | | 19. Informant's Name/Relationship (Type, Print) CELIA GOLDMAN / WIFE | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3631 GLENGYLE AVE. #A-6 - BALTIMORE, MD 21215 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON CHIZUK AMUNO | | 20c. Location - City or Town, State BALTIMORE, MD | | 21. Signature of Funeral Service Licensee | |
| 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | 23a. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Myocardial Infarction Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 11/15/99 | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| 29b. Signature and title of certifier | | 29c. License number D51426 | | 29d. Date signed (Month, Day, Year) 11.13.99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eliot Rothschild 4000 Old Court, Pikesville, MD 21208 | | 31. Date filed (Month, Day, Year) NOV 17 1999 | |
| 32. Registrar's Signature | | 33. State Registrar | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | 35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. | | 36. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once. | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36051

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lucy Verdell Gordon

2. Date of Death

November 11, 1999 10:50

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Lorien Nursing Home

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

218-03-6864

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 26, 1916

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3714 Sylvan Drive

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th Grade

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Foster Care Parent

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Jarvis

18. Mother's Name (First, Middle, Maiden Surname)

Lucy V. Harris

19e. Informant's Name/Relationship (Type, Print)

John E. Gordon

son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12600 Golden Oak Drive Ellicott City, Md. 21042

20e. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Md. National Mem. Park

Date

Nov. 17

20c. Location - City or Town, State

Laurel, Md.

21. Signature of Funeral Service Licensee

Ernest R. Perry, Jr.

22. Name and Address of Facility

Nutter Funeral Homes, Inc.
2501 Gwynns Falls PKWY Baltimore, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Congestive heart failure

Due to (or as a consequence of):

b. End stage renal disease

Due to (or as a consequence of):

c. hypertension

Due to (or as a consequence of):

d. Valvular heart disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ernest R. Perry, Jr.

29c. License number

D31927

29d. Date signed (Month, Day, Year)

November 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ho-Lai Feng; LORIE NURSING HOME; HOWARD, MD

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

Ernest R. Perry, Jr.

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36052

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ZOLA E GALVEZ | | | | 2. Date of Death Month 11 Day 15 Year 99 | | 3. Time of Death 1155 PM | |
| | 4a. Facility Name (If not Institution, give street and number) UNIVERSITY OF MARYLAND HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 216-06-8968 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 73 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 03-07-1926 | 9. Birthplace (State or Foreign Country) Guatemala |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md. | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 2917 Montebello Terrace | | | | 10f. Zip Code 21214 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Guatemalaian | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 3 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker | | 16b. Kind of Business/Industry Own Home | | | |
| | 17. Father's Name (First, Middle, Last) Emilio Gonzalez | | | | 18. Mother's Name (First, Middle, Maiden Surname) Clara Gonzalez | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Anabella Ayestas -Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12000 Cedar Lane, Kingsville, Md. 21087 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery | | Data 11-18-99 | | 20c. Location - City or Town, State Baltimore, Md | |
| | 21. Signature of Funeral Service Licensee Gary R. DiGiovanni | | | | 22. Name and Address of Facility Leonard J. Ruck Funeral Home 5305 Harford Rd. Baltimore, Md 21214 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. INTRABDOMINAL HEMORRHAGE Due to (or as a consequence of): b. COAGULOPATHY Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 12 HOURS 1 WEEK | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ISCHEMIC CARDIOMYOPATHY | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Wilbur Y Kuo mo | | 29c. License number P13386 | | 29d. Date signed (Month, Day, Year) 11/15/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Wilbur Y Kuo - UMMS - Green St - Baltimore, Md. | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature G. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

99-6816-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

MICHAEL

State of Maryland / Department of Health and Mental Hygiene

99 36053

GUEST

AMEND#23A, 27, 28 F PER M.E.O. G777 11-24-99 J.A. Certificate of Death

Reg. No.

| | | | | | | | | | | | | | |
|--|--|--|---|--|---|--|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MICHAEL S. GUEST | | | | | 2. Date of Death Month Day Year NOVEMBER 14, 1999 | | 3. Time of Death 8:18P.M. | | | | | |
| | 4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | | | | |
| Funeral Director | 5. Social Security Number 214-80-3000 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 39 Yrs. | | 8. Date of Birth (Month, Day, Year) AUG. 22, 1960 | | 9. Birthplace (State or Foreign Country) MARYLAND | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | |
| 10a. State MARYLAND | | | 10b. County N/A | | | 10c. City, Town or Location BALTIMORE | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 10e. Street and Number 1510 HOMESTEAD STREET | | | | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? U.S.A. | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. AFRO-AMERICAN | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH College (1-4 or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BRICKLAYER/cabinet maker | | | 16b. Kind of Business/Industry HOME IMPROVEMENT | | | | | |
| 17. Father's Name (First, Middle, Last) GEORGE A. GUEST | | | | | 18. Mother's Name (First, Middle, Maiden Surname) RUTH FONSECA | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) RUTH DORSEY/ MOTHER | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 MELVILLE AVE. BALTO, MD. 21218 | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEM. | | | Date NOV. 20, 1999 | | 20c. Location - City or Town, State BALTO, MD. | | | | | |
| 21. Signature of Funeral Service Licensee <i>Bernadine V. Scruggs</i> | | | | | 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO, MD. 21213 | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ETHANOL AND NARCOTIC INTOXICATION a. _____ Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) 11/14/99 | | 28b. Time of Injury unknown M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred UNKNOWN | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND IN HOUSE | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1507 E. 28th ST. BALTO. CITY, MD. | | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Joseph Pestaner M.D.</i> | | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) NOVEMBER 15, 1999 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | | | | 32. Registrar's Signature <i>David B. Sparks</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

12-9-99 WR

Certificate of Death

Reg. No.

99 36054

AMEND ITEMS: #23 PART I, 27 PER

| | | | | | | | | | | |
|---|--|---|--|---|--|---|--------------------------------|---|------------------------------------|--|
| Physician /Medical Examiner | 1. Decedant's Name (First, Middle, Last) IRVIN GOINES, SR | | | | 2. Date of Death Month Day Year NOVEMBER 14, 1999 | | | | 3. Time of Death 1255 PM | |
| | 4a. Facility Name (If not institution, give street and number) 2304 OCALA AVENUE - APARTMENT 2 | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 216-28-3308 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) 07-09-31 | | 9. Birthplace (State or Foreign Country) MD | | Usual Residence of Decedent | | 10a. State MD | | 10b. County N/A | |
| 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 2304 OCALA AVENUE | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9TH GRADE College (1-4 or 5+) N/A | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SELF EMPLOYED | | 16b. Kind of Business/Industry | | 17. Father's Name (First, Middle, Last) WILLIAM ROBINSON | | 18. Mother's Name (First, Middle, Maiden Surname) MELINDA GOINES | | 19a. Informant's Name/Relationship (Type, Print) IRVIN GOINES / SON | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 SANDBURY AVE., GLEN BURNIE MD. 21060 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY | | 20c. Date 11-20-99 | | 20d. Location - City or Town, State BALTO. MD | | |
| 21. Signature of Funeral Service Licensee Vaughn C. Greene | | 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 6151 BALTO. NAT'L PIKE. BALTO. MD. 21229 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MYOCARDIAL FIBROSIS | | Approximate Interval Between Onset and Death | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Maureen McNeill MD | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) NOVEMBER 15, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter A. Koran 111 Penn Street, Baltimore, Maryland 21201 | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature B. Sparks | | State Registrar | | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form. | | Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36055

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPHINE M. HOWARD

2. Date of Death

November 12 1999 1:57AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

236.76.0857

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11/27/45

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10e. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

709 BERRY ROAD

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JESSE MONTGOMERY

18. Mother's Name (First, Middle, Maiden Surname)

HILDA MONTGOMERY

19a. Informant's Name/Relationship (Type, Print)

PAUL D. HOWARD - HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

709 BERRY ROAD GLEN BURNIE, MD 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GLEN HAVEN MEM. PK.

Date

11/15

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature of Funeral Service Licensee

KELLY GREGORY FINK

22. Name and Address of Facility

FINK FUNERAL HOME, PA
426 CRAIN HWY., SW., GLEN BURNIE, MD 2106123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Chronic Renal Failure

Yes

Due to (or as a consequence of):

b. DM, HTN, Dilated Cardiomyopathy

Yes

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Babak Inan MD

29c. License number

H0053939

29d. Date signed (Month, Day, Year)

11/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

301 Hospital Dr Glen Burnie md 21061

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

Benita S Sparks

State
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

5

Josephine Howard

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36056

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DAVID A. HORKY

2. Date of Death
Month Day Year
NOVEMBER 13, 19993. Time of Death
0730

4a. Facility Name (If not institution, give street and number)

1310 GATWICK ROAD

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

220.56.8918

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

46

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

2/12/53

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1310 GATWICK ROAD

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SUPERVISOR

16b. Kind of Business/Industry

SARGENT BUILDERS

17. Father's Name (First, Middle, Last)

JAMES W. HORKY, SR.

18. Mother's Name (First, Middle, Maiden Surname)

HELEN ANTHONY

19a. Informant's Name/Relationship (Type, Print)

THERESA ARNOLD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

450 Glenmar Road B-4, Glen Burnie, MD 21061

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

11/15

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Kelly Gregory Fink

22. Name and Address of Facility Fink Funeral Home, PA

426 Crain Hwy., SW., Glen Burnie, MD 21061

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Extensive stage Small cell lung cancer

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): Limited stage mixed small cell lung cancer

Due to (or as a consequence of): all of non-small cell lung cancer

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

D 39041

29d. Date signed (Month, Day, Year)

November 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GIAYATRI Nimmagadda 3001 S. Hanover Street Baltimore MD 21225

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

Sparks

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36057

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Johnnie Mae Hawkins

2. Date of Death

November 15, 1999

3. Time of Death

1823

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral
Director

5. Social Security Number

213-14-2389

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 16, 1917

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2705 Ruscomb Lane

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

factory

17. Father's Name (First, Middle, Last)

John Walker

18. Mother's Name (First, Middle, Maiden Surname)

Louanna Walker

19a. Informant's Name/Relationship (Type, Print)

Betty Heard daughter 2705 Ruscomb Lane Balto MD 21215

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

11/17/99 Catonsville, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Albert P. Wylie funeral Hm PA

638 N. Guilford St. Baltimore, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute Myocardial Infarction

Approximate Interval Between Onset and Death

Sudden

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

Arteriosclerotic Heart Disease

10 yrs

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma of Lung, Chronic Renal Insufficiency,

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. [Signature]

29c. License number

D 09212

29d. Date signed (Month, Day, Year)

11/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Woodholme Medical Bldg. 1838 Green Tree Rd. Baltimore MD 21216

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Patient Known As: Hawkins, Johnnie M.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36058

| | | | | | | | | |
|--|--|--|--------------------------|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edgar Hankin | | | | 2. Date of Death Month Day Year November 13, 1999 | | 3. Time of Death 10:30am | |
| | 4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore | | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 214-18-3556 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) SEP. 18, 1919 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State ILL | | 10b. County LAKE | | 10c. City, Town or Location BARRINGTON | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 Yes 2 No | | 10e. Street and Number 20856 SWANSWAY DRIVE | | 10f. Zip Code 60010 | | |
| 10g. Citizen of What Country? U.S.A. | | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | |
| 14. Race - American Indian, Black, White, etc. WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MASTER PLUMBER | | 16b. Kind of Business/Industry PLUMBING | | |
| 17. Father's Name (First, Middle, Last) SIMON HANKIN | | | | 18. Mother's Name (First, Middle, Maiden Surname) SARA FRANK | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ROGER HANKIN / SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20856 SWANSWAY DRIVE - BARRINGTON, ILL 60010 | | | | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BETH EL MEMORIAL PARK | | Date 11/15/99 | | 20c. Location - City or Town, State RANDALLSTOWN, MD | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | | |
| 23a. Part I. Enter the disease, or combination of diseases, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | |
| Approximate Interval Between Onset and Death 2 weeks | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Glioblastoma | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | |
| 24a. Was an autopsy performed? 1 Yes 2 No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | |
| 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Karen Babitt, M.D. | | | | 29c. License number RES 000 | | 29d. Date signed (Month, Day, Year) November 13, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karen Babitt, 2401 W. Belvedere Avenue, Baltimore, MD 21215 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36059

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARION

HARRIS

2. Date of Death
Month Day Year
NOVEMBER 7, 1999

3. Time of Death
4:19 PM

4a. Facility Name (If not institution, give street and number)

HOSPICE OF BALTIMORE GILCHRIST CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number
219-26-7567

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)
61 Yrs.

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)
FEB.15,1938

9. Birthplace (State or Foreign Country)
GERMANY

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4742 BYRON ROAD

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.
Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (9-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

SOCIAL WORK

17. Father's Name (First, Middle, Last)

SIMON

LEWIN

18. Mother's Name (First, Middle, Maiden Summa)

VIOLET

LEVY

19a. Informant's Name/Relationship (Type, Print)

STEVEN HARRIS / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1404 BELLONA AVENUE - LUTHERVILLE, MD 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

BETH TFILOH CEMETERY

Date

11/9/99

20c. Location - City or Town, State

WOODLAWN, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Breast Cancer
Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death
20⁺ years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury
(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier
(Check only
one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] W.A. Riley, MD

29c. License number

025205

29d. Date signed (Month, Day, Year)

November 8, 1999

30. Name and address of person who completed cause of death (from 23a) (Type, Print)

W.A. Riley 6701 N. Charles St. Balto. md 21208

31. Date filed (Month, Day, Year)

NOV 16 1999

32. Registrar's Signature

[Signature] G. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Marion Harris 11/7/99 4 PM

[Signature]

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36060

| | | | | | | | | |
|--|---|--|---|--|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Corine Haywood | | | | 2. Date of Death Month November Day 12 Year 1999 | | 3. Time of Death 6:45 a.m. | |
| | 4e. Facility Name (If not institution, give street and number) 3712 Barrington Road | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 216-28-2928 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 84 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept. 12, 1915 | 9. Birthplace (State or Foreign Country) S.C. |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md. | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 3712 Barrington Rd. | | | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade | | College (1-4 or 5+) Housekeeper | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeper | | 16b. Kind of Business/Industry Stella Maris - Hospice | |
| | 17. Father's Name (First, Middle, Last) Wash David | | | | 18. Mother's Name (First, Middle, Maiden Surname) Annie Lee Dingle | | | |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print) Ruth J. Hill Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8418 Church Lane Randallstown, MD. 21133 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park | | Date Nov. 18 | | 20c. Location - City or Town, State Baltimore, Md. | |
| | 21. Signature of Funeral Service Licensee Herbert E. Nutter | | | | 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy Balto., MD. 21216 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIO PUL MONARY ARREST b. CHF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. d. | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES, Decubiti CAD, HBP, PVD, RENAL INSUFFICIENCY | | | | | | | |
| State Registrar | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29b. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 29a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 29b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Alan M. Shorofsky MD | | | | | | | | |
| 29b. Signature and title of certifier Alan M. Shorofsky MD | | | | 29c. License number 024569 | | 29d. Date signed (Month, Day, Year) 11/12/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan M. Shorofsky 515 FAIRMOUNT AVE; TOWSON, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | | | 32. Registrar's Signature B. Sparks | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36061

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|---|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Oscar W. Haynie | | | | 2. Date of Death Month Day Year November 11, 1999 | | 3. Time of Death 6:05pm | |
| | 4a. Facility Name (If not institution, give street and number) FutureCare-Cherrywood | | | | 4b. City, Town, or Location of Death Reisterstown | | 4c. County of Death Baltimore County | |
| Funeral Director | 5. Social Security Number 225-20-9551 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) FEB. 28, 1923 | | 9. Birthplace (State or Foreign Country) Virginia |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Carroll | | 10c. City, Town or Location Manchester | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 3260 Maple Avenue, PoBox 654 | | | | 10f. Zip Code 21102 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician | | 16b. Kind of Business/Industry Electrical | | |
| 17. Father's Name (First, Middle, Last) ERNST | | | | 18. Mother's Name (First, Middle, Maiden Surname) GENOVA (unk.) | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Patricia Haynie (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3260 Maple Ave., P.O. box 654, Manchester, MD. 21102 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery | | 20c. Date Nov. 16 | | 20d. Location - City or Town, State Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee M. J. Marshall | | | | 22. Name and Address of Facility 736 Edmondson Ave. Catonsville, MD, 21228 Sterling-Ashton-Schwab Funeral Home, Inc. | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 10 yrs | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Robert L. Moss | | | | 29c. License number 032882 | | 29d. Date signed (Month, Day, Year) 11/15/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert L. Moss 114 Business Center Dr. Reisterstown, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | | | 32. Registrar's Signature B. Sparks | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

17/12/11

CARL D. INGRAM G780

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G777 11-29-99 WR.

Certificate of Death

Reg. No. 99 36062

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Carl Dewhight INGRAM | | 2. Date of Death Month Day Year NOVEMBER 11, 1999 | | 3. Time of Death 1207 PM | |
| 4a. Facility Name (If not institution, give street and number) ECONO LODGE MOTEL | | 4b. City, Town, or Location of Death PIKESVILLE | | 4c. County of Death BALTIMORE | |
| 5. Social Security Number 215-86-9077 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 37 Yrs. | |
| 8. Data of Birth (Month, Day, Year) 9/18/62 | | 9. Birthplace (State or Foreign Country) MD. | | | |
| 10a. State MD. | | 10b. County W/A | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 5112 Pembroke Ave | | 10f. Zip Code 21215 | |
| 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) GROCERY stocker | | 16b. Kind of Business/Industry Seven Mile Lane Market | |
| 17. Father's Name (First, Middle, Last) Robert N. INGRAM | | 18. Mother's Name (First, Middle, Maiden Surname) Matilda Brooker | | | |
| 19a. Informant's Name/Relationship (Type, Print) Matilda Brooker | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5112 Pembroke Ave. Baltimore MD. 21215 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery | | 20c. Location - City or Town, State 11/16/99 Baltimore, Maryland | |
| 21. Signature of Funeral Service Licensee Betts Funeral Home | | 22. Name and Address of Facility 1129 N. Caroline St. Baltimore, Md. 21213 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. VENTRICULAR DILATATION AND NARCOTIC INTOXICATION COMPLICATING RIGHT NARCOTIC INTOXICATION COMPLICATING CONGESTIVE HEART DISEASE | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 11-11-99 | | 28b. Time of Injury Found: 12:00 | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred UNKNOWN | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) ECONO LODGE MOTEL, PIKESVILLE, MD. | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier Therese M. King | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) NOVEMBER 12, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Therese M. King 111 PENN STREET BALTIMORE, MARYLAND 21201 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature Apata | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36063

Certificate of Death

Reg. No.

| | | | | | |
|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Angeline Ierise | | 2. Date of Death Month Day Year November 15, 1999 | | 3. Time of Death 8:15 PM |
| | 4a. Facility Name (If not institution, give street and number) 2506 Gray Manor Terrace | | 4b. City, Town, or Location of Death Dundalk | | 4c. County of Death Baltimore |
| Funeral Director | 5. Social Security Number 235-04-8017 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | 8. Date of Birth (Month, Day, Year) Jan. 1, 1914 | 9. Birthplace (State or Foreign Country) West Virginia |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Baltimore | 10c. City, Town or Location Dundalk | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 2506 Gray Manor Terrace | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? United States |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (14 or 5+) | | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | |
| | 17. Father's Name (First, Middle, Last) Frank Leon | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Louise Giovan | | |
| | 19a. Informant's Name/Relationship (Type, Print) Victoria Ritchie (Daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2506 Gray Manor Terrace Dundalk, Maryland 21222 | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Highland Hills Mem. Gdns. | | 20c. Location - City or Town, State Follansbee, WV |
| Physician /Medical Examiner | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | |
| | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Arteriosclerotic Heart Disease</i> Due to (or as a consequence of): b. <i>Arteriosclerosis</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alzheimer's Disease</i> | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| State Registrar | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form. | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number 2011150 |
| | 29d. Date signed (Month, Day, Year) 11/16/1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MELITO M. TORRES, MD 441 S. ELLWOOD AVE, BALTO, MD 2124 | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36064

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Jones

2. Date of Death

November 14, 1999

3. Time of Death

10:30 pm

4a. Facility Name (If not institution, give street and number)

4549 Shamrock Ave.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral
Director

5. Social Security Number

212-50-5781

6. Sex

M

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year

July 2, 1946

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4549 Shamrock Ave.

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (14 or 5+)

12th 8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

disabled

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

James Jones

18. Mother's Name (First, Middle, Maiden Surname)

Mattie William

19a. Informant's Name/Relationship (Type, Print)

Alfred Jones brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5818 Daybreak Ter. Baltimore, MD 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Western Star

Date

11/18/99

20c. Location - City or Town, State

Catonville, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Alfred Jones Funeral Hm PA
638 N. Calver St. Baltimore, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ESOPHAGEAL CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. TONGUE CARCINOMA

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D52228

29d. Date signed (Month, Day, Year)

11/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIPULKUMAR BHADURIYA, MD 3007 E-NORTHERN PKWY, BALTIMORE, MD 21214

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36065

Certificate of Death

Reg. No.

| | | | | | |
|---|---|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Hazel James | | 2. Date of Death Month 11 Day 14 Year 99 | | 3. Time of Death 0630 |
| | 4e. Facility Name (If not institution, give street and number) 1349 Winton Ave | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N.A |
| Funeral Director | 5. Social Security Number 213 18 7283 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) 8-18/12 | | 9. Birthplace (State or Foreign Country) MD | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10c. City, Town or Location Balto | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. State MD | 10b. County N.A | 10f. Zip Code 21239 | | 10g. Citizen of What Country? U.S.A |
| | 10e. Street and Number 1349 Winton Ave | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LAUNDRESS | | 16b. Kind of Business/Industry F.S.K |
| | 17. Father's Name (First, Middle, Last) Garfield James | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Holland | | |
| | 19e. Informant's Name/Relationship (Type, Print) Gehlyn Bacote | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6580 PIONEER CT BALTO, MD 21214 | | |
| | 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT Zion Cem | | 20c. Location - City or Town, State 11/19/99 LANDSDOWNE MD |
| | 21. Signature of Funeral Service Licensee Joseph B. Locks Jr | | 22. Name and Address of Facility Joseph B. Locks Jr 311 1304 N. Central Ave | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Intractable lower extremity wound infection Due to (or as a consequence of): b. known insufficiency of lower extremities Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death 5 months 5 years | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Failure to thrive, sarcopenia | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28e. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Dr. [Signature] MD | | 29c. License number DD053115 | |
| 29d. Date signed (Month, Day, Year) Nov 17, 1999 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Jeff Landerman 201 E. Univ Parkway, Balt, MD 21218 | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature [Signature] | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36066

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|--|--|---|--|--|---|--|--|---|---|---|--|--|---|----|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Barbara Jennings</i> | | | | 2. Date of Death Month <i>Nov</i> Day <i>14</i> Year <i>1999</i> | | 3. Time of Death <i>12:45p</i> | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical System</i> | | | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | 4c. County of Death <i>N/A</i> | | | | | | | |
| Funeral Director | 5. Social Security Number <i>215-28-9883</i> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>73</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>Jan. 12, 1926</i> | 9. Birthplace (State or Foreign Country) <i>Washington, D.C.</i> | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| 10a. State <i>MD.</i> | | 10b. County <i>Baltimore</i> | | 10c. City, Town or Location <i>Randallstown</i> | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 10e. Street and Number <i>3807 Pikeswood Drive</i> | | | | 10f. Zip Code <i>21133</i> | | 10g. Citizen of What Country? <i>USA</i> | | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>School Secretary</i> | | | 16b. Kind of Business/Industry <i>Baltimore City Public School</i> | | | | | | | |
| 17. Father's Name (First, Middle, Last) <i>Robert + Moore</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Mozelle Ash</i> | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Husband <i>William Jennings, Sr.</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3807 Pikeswood Drive Randallstown md. 21133</i> | | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Md. National Mem. Park</i> | | 20c. Location - City or Town, State <i>Nov. 20 Laurel, MD.</i> | | 20d. Date | | | | | | | | |
| 21. Signature of Funeral Service Licensee <i>Ernest R. Perry, Jr.</i> | | | | 22. Name and Address of Facility <i>Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy Baltimore, MD. 21216</i> | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. <i>Herniation Syndrome</i> Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. <i>Elevated ICP</i> Due to (or as a consequence of):</td> </tr> <tr> <td>c. <i>Subarachnoid hemorrhage</i> Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> </table> | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <i>Herniation Syndrome</i> Due to (or as a consequence of): | Approximate Interval Between Onset and Death | b. <i>Elevated ICP</i> Due to (or as a consequence of): | c. <i>Subarachnoid hemorrhage</i> Due to (or as a consequence of): | d. |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <i>Herniation Syndrome</i> Due to (or as a consequence of): | Approximate Interval Between Onset and Death | | | | | | | | | | | | |
| | b. <i>Elevated ICP</i> Due to (or as a consequence of): | | | | | | | | | | | | | |
| | c. <i>Subarachnoid hemorrhage</i> Due to (or as a consequence of): | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | |
| | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Matthew Mattingly MD</i> | | | | 29c. License number <i>P12246</i> | | 29d. Date signed (Month, Day, Year) <i>Nov 14, 1999</i> | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>22 South Green St., Baltimore, MD 21210</i> | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>NOV 17 1999</i> | | 32. Registrar's Signature <i>Barbara B. Spack</i> | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36067

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|---|---|--------------------------------|---|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) AUDREY JACKSON-JOHNSON | | | | 2. Date of Death Month Day Year November 10, 1999 | | | | 3. Time of Death 12:28 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) 222 South Washington Street | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 218-74-4875 | 6. Sex 1 M 2 F | 7. Age (In yrs. last birthday) 40 | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JULY 26, 1959 | | 9. Birthplace (State or Foreign Country) MARYLAND | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | 10b. County N/A | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits 1 Yes 2 No | | | |
| | 10e. Street and Number 2405 E. OLIVER STREET | | | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 Yes 2 No | | 14. Race - American Indian, Black, White, etc. AFRO-AMERICAN | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 YEARS | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY | | | | 16b. Kind of Business/Industry BALTIMORE CITY | | | |
| | 17. Father's Name (First, Middle, Last) WILLIAM L. JACKSON | | | | 18. Mother's Name (First, Middle, Maiden Surname) ANN HIGHSMITH | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) WILLIAM L. JACKSON/FATHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5701 THE ALAMEDA BALTO, MD. 21239 | | | | | |
| | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE CEMETERY NOV. 16, 1999 BALTO, MD. | | 20c. Location - City or Town, State | | | | | |
| | 21. Signature of Funeral Service Licensee <i>Bernadine V. Scruggs</i> | | | | 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Stab wound of Back of Chest | | | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| Physician /Medical Examiner | 23c. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | | 24a. Was an autopsy performed? 1 Yes 2 No | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | | | | | | | |
| | 25. Was case referred to medical examiner? 1 Yes 2 No | | | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) at scene | | | | | |
| | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) UNK | | 28b. Time of Injury UNK M | | 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred Subject stabbed | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Unknown | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Unknown | | | | | | | |
| State Registrar | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number O.C.M.E. | |
| | 29d. Date signed (Month, Day, Year) November 11, 1999 | | | | | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. L. Johnson, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

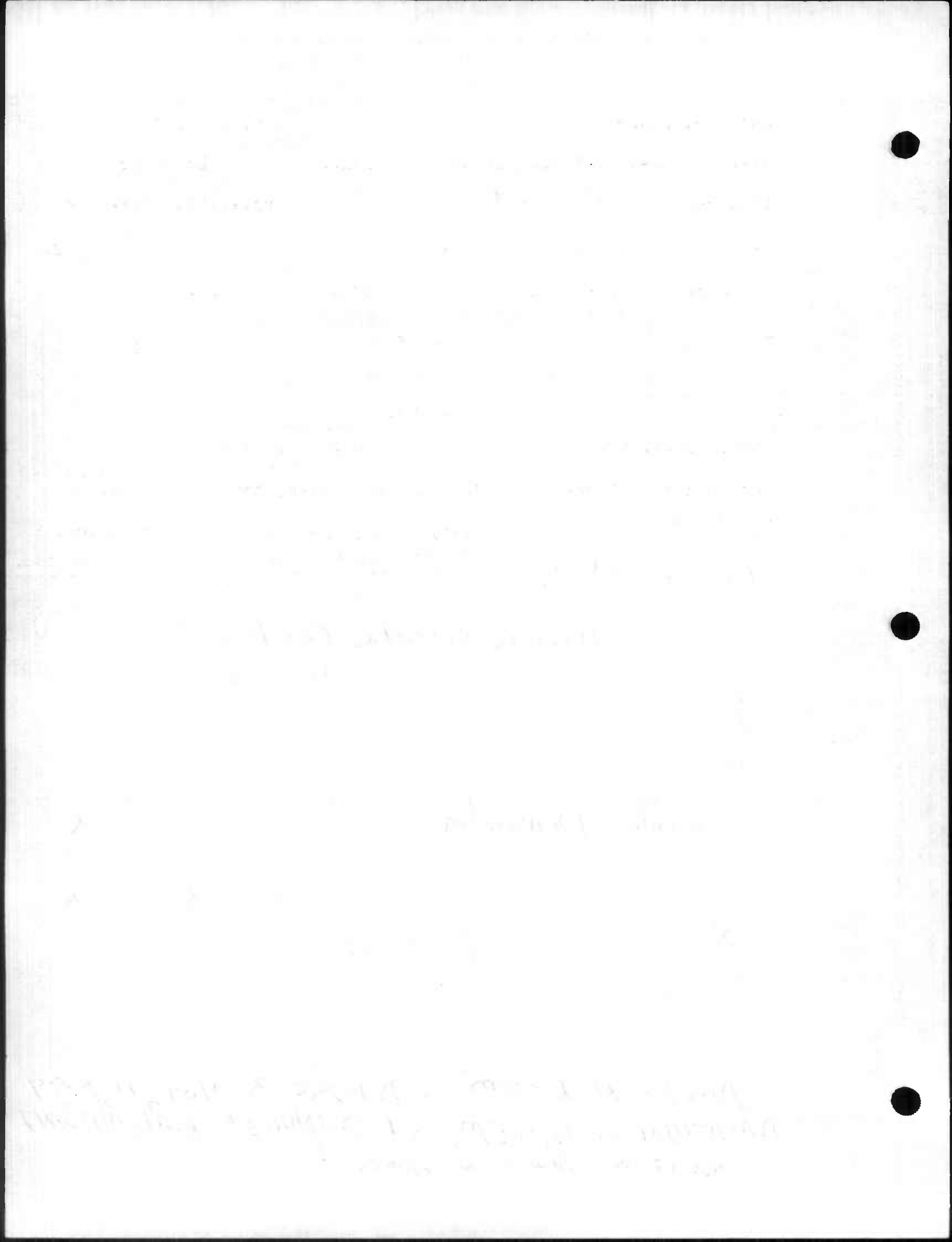
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36068

| | | | | | | | | |
|---|--|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Helen D. Jones | | | | 2. Date of Death Month Day Year Nov. 10, 1999 | | 3. Time of Death 8:30 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) Dulaney Valley Assisted Living | | | | 4b. City, Town, or Location of Death Baldwin | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 216-03-0461 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 87 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 1, 1912 | |
| | 9. Birthplace (State or Foreign Country) Virginia | | 10a. State Md. | | 10b. County Baltimore | | 10c. City, Town or Location Baldwin | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 5001 Carroll Manor Road | | 10f. Zip Code 21013 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | 16b. Kind of Business/Industry Office | | 17. Father's Name (First, Middle, Last) Robert Jones, Sr. | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Marie E. Dean | | 19a. Informant's Name/Relationship (Type, Print) Linda Jones / Niece | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9106 Abigail Drive, Apt. 2 D, Balto., Md 21237 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park | | 20c. Location - City or Town, State 11-12-99 Elkridge, Md. | | 21. Signature of Funeral Service Licensee MSHC. Maryland | | 22. Name and Address of Facility Bradley-Ashton-Matthews Funeral Home Inc. 2134 Willow Spring Rd. Baltimore, Md 21222 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Senile Dementia | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Amatur M. Haqem | |
| | 29c. License number D15503 | | 29d. Date signed (Month, Day, Year) Nov. 11, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMATUR M. HAQEM, 501 Dolphin St, Balto MD 21217 | | 31. Data filed (Month, Day, Year) NOV 17 1999 | |
| State Registrar | 32. Registrar's Signature [Signature] | | 33. Registrar's Signature [Signature] | | 34. Registrar's Signature [Signature] | | 35. Registrar's Signature [Signature] | |
| | 36. Registrar's Signature [Signature] | | 37. Registrar's Signature [Signature] | | 38. Registrar's Signature [Signature] | | 39. Registrar's Signature [Signature] | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36069

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|--|---|---|---|-----------------------------------|--|----------------------------------|--|---------------------------------------|-------|----------------------------------|--|--|----|--|----|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JACK THOMAS KING | | | | 2. Date of Death Month November Day 14 Year 1999 | | 3. Time of Death 5:38 P | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) FALLSTON GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death FALLSTON | | 4c. County of Death HARFORD | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 280 24 2287 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) SEPT 21 1928 | | 9. Birthplace (State or Foreign Country) PENNSYLVANIA | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | 10b. County HARFORD | 10c. City, Town or Location FOREST HILL | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| | 10e. Street and Number 325 MONTGOMERY DRIVE | | | 10f. Zip Code 21050 | | 10g. Citizen of What Country? U.S.A. | | | | | | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1945 to 1980 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS College (1-4 or 5+) 2 YRS. | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) L W 3 | | 16b. Kind of Business/Industry UNITED STATES ARMY | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) ROBERT LES KING | | | | 18. Mother's Name (First, Middle, Maiden Summa) RUTH WILLIAMS | | | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) B. JEAN KING | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 325 MONTGOMERY DRIVE FOREST HILL, MARYLAND 21050 | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) EVAN FUNERAL CHAPEL - BEL AIR, P.A. | | 20c. Location - City or Town, State FOREST HILL MARYLAND | | 20d. Date NOV 15, 1999 | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee [Signature] | | | | 22. Name and Address of Facility EVAN FUNERAL CHAPEL - BEL AIR, P.A. 31 NEWPORT DRIVE FOREST HILL, MARYLAND 21050 | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Ventricular Tachycardia</td> <td>Approximate Interval Between Onset and Death minutes</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">b. Chronic Respiratory Failure</td> <td rowspan="2">years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Ventricular Tachycardia | Approximate Interval Between Onset and Death minutes | Due to (or as a consequence of): | | b. Chronic Respiratory Failure | years | Due to (or as a consequence of): | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. | | d. |
| Immediate Cause (Final disease or condition resulting in death) | a. Ventricular Tachycardia | Approximate Interval Between Onset and Death minutes | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | |
| | b. Chronic Respiratory Failure | years | | | | | | | | | | | | | | | | | | | |
| | | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. | | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | | | 29c. License number MD D 18779 | | 29d. Date signed (Month, Day, Year) November 15, 1999 | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Albert S. C. Sun, M.D. 1800 Harford Road Fallston MD 21047 | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature [Signature] | | | | | | | | | | | | | | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

99 36070

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Louis G. Kelbaugh | | | | 2. Date of Death Month November Day 13 Year 1999 | | | | 3. Time of Death 8:05AM | |
| | 4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death Rosedale | | | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 215-28-7046 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | 8. Date of Birth (Month, Day, Year) November 19, 1926 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10e. Street and Number 2232 Coralhorn Road | | | | 10f. Zip Code 21220 | | 10g. Citizen of What Country? United States | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (14 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | | | 16b. Kind of Business/Industry Bethlehem Steel Corp. | |
| | 17. Father's Name (First, Middle, Last) Edward Kelbaugh | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marie (unavailable) | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Madeline H. Kelbaugh (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2232 Coralhorn Road, Baltimore, Maryland 21220 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery | | 20c. Location - City or Town, State 11-17-99 Dundalk, Maryland | | | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Carol A. Delm | | | | 22. Name and Address of Facility CAFA, Stephen D. Lohrmann, P.A. 8717 Green Pastures Drive, Baltimore, MD 21286 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 3 days 5 years | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Anita Philip | | | | 29c. License number RD196667 | |
| | 29d. Date signed (Month, Day, Year) November 13, 1999 | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Anita Philip 9000 Franklin Square Drive Baltimore, Maryland 21237 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature Benita B. Sparks | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36071

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Beulah Maxine Kitzmiller | | 2. Date of Death Month November Day 15 , Year 1999 | | 3. Time of Death 10:40 PM | |
| 4a. Facility Name (If not institution, give street and number) 7019 Greenbank Road | | | 4b. City, Town, or Location of Death Middle River | | 4c. County of Death Baltimore |
| 5. Social Security Number 219 34 0767 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 81 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept. 1, 1918 |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Middle River | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 7019 Greenbank Road | | | |
| 10f. Zip Code 21220 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) College | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) Uriases Sines | | | 18. Mother's Name (First, Middle, Maiden Surname) Dora Rodaheiver | | |
| 19a. Informant's Name/Relationship (Type, Print) Joe Wallace (son) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7019 Greenbank Road Middle River, Maryland 21220 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Mem. Gardens | | 20c. Location - City or Town, State 11/18/99 Baltimore County, Md. | |
| 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility Brudzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic renal failure Due to (or as a consequence of): b. Diabetes mellitus Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | Approximate Interval Between Onset and Death 1 year 20 years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - Congestive heart failure 2 years | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number 101021 | | 29d. Date signed (Month, Day, Year) 11/16/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Miquel A. Castro Jr 107 Beacon Rd. Balto MD 21220 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36072

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Corretta Lee</i> | | | | 2. Date of Death Month <i>Nov</i> Day <i>13</i> Year <i>99</i> | | 3. Time of Death <i>11:17 PM</i> | | |
| | 4a. Facility Name (If not institution, give street and number) <i>Bon Secours Hospital 2000 W. Baito. St.</i> | | | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | 4c. County of Death <i>N/A</i> | | |
| Funeral Director | 5. Social Security Number <i>220 64 2757</i> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>44</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>Aug 11, 1955</i> | 9. Birthplace (State or Foreign Country) <i>S. Carolina</i> | |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location <i>Baltimore</i> | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| To Be Completed by Funeral Director | 10a. State <i>MD</i> | 10b. County <i>N/A</i> | 10e. Street and Number <i>202 N. Mount St. Apt 202</i> | | | 10f. Zip Code <i>21223</i> | 10g. Citizen of What Country? <i>USA</i> | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4or 5+) <i>2 yrs</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Secretary</i> | | 16b. Kind of Business/Industry <i>STATE GOV'T</i> | | | | |
| | 17. Father's Name (First, Middle, Last) <i>Brayell Lee</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Martha Mae Smith</i> | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) <i>Jeane Thompson (Fiance')</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>202 N. Mount St Apt 202 Baltimore 21223</i> | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metro Crematory</i> | | 20c. Location - City or Town, State <i>11/18/99 Catonsville, Md</i> | | 20d. Date <i>11/18/99</i> | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility <i>CAPLE FUNERAL SERVICE 5502 Winner Ave Balto, Md. 21215</i> | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>CARDIO PULMONARY ARREST</i> Due to (or as a consequence of): b. <i>SEVERE PULMONARY Hypertension</i> Due to (or as a consequence of): c. <i>SLEEP APNEA</i> Due to (or as a consequence of): d. <i>EXOGENOUS OBESITY</i> | | | | Approximate Interval Between Onset and Death | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <i>Hypothyroidism, Hypertension</i> | | | | | | 23b. Did tobacco use contribute to the causa of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner as stated. | | 29b. Signature and title of certifier <i>[Signature] M.D. FA HAMILTON, MD</i> | | 29c. License number <i>DO8291</i> | | 29d. Date signed (Month, Day, Year) <i>11-13-99</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Bon Secours Hospital, 2000 W. Baltimore St. Baltimore, Md, 21223</i> | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>NOV 17 1999</i> | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

RECEIVED VOM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMEND#10c PER A.B. G777 11-17-99 J.A.

Reg. No.

99 36073

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alexander Love

2. Date of Death
Month Day Year

September 24, 1999 12:10AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Mariner Health of Southern Maryland

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

579-20-9323

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

03/30/1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Forrestville

FORESTVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6026 Parkland Court #201

10f. Zip Code

20747

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
unknown

College (1-4 or 5+)

mover

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Furniture

17. Father's Name (First, Middle, Last)

Willie Love

18. Mother's Name (First, Middle, Maiden Surname)

Sally Arrington

19a. Informant's Name/Relationship (Type, Print)

Lawan Poole/neice

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10771 Esprite Place White Plains, MD 20695

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial infarction

Due to (or as a consequence of):

10m

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary artery disease

Due to (or as a consequence of):

5h

c. Hypertension

Due to (or as a consequence of):

10m

d. Old CVA

10m

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ronald S. Wade, Director

29c. License number

S-24535

29d. Date signed (Month, Day, Year)

11.4.99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State
Registrar

31. Date filed (Month, Day, Year)

NOV 16 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten signature

NOV 1 8 1953

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36074

| | | | | | | | | |
|---|---|---|--|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LEONARD H. LINDNER | | | | 2. Date of Death Month November Day 15 Year 1999 | | 3. Time of Death 1:22 P.M. | |
| | 4a. Facility Name (If not Institution, give street and number) NORTH ARUNDEL HOSPITAL | | | | 4b. City, Town, or Location of Death Glen Burnie | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 213.26.4547 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 70 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 6/10/1929 | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location GLEN BURNIE | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 107 Dickens street | | | | 10f. Zip Code 21061 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 47-49 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dispatcher | | | 16b. Kind of Business/Industry Roadway Express | |
| 17. Father's Name (First, Middle, Last) Henry L. Lindner | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marie Kaiser | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ida M. Hall | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Dickens Street, Glen Burnie, MD 21061 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. PK. | | Date 11.18 | | 20c. Location - City or Town, State Elkridge, MD | | |
| 21. Signature of Funeral Service Licensee <i>Kelly Gregory Fink</i> Kelly Gregory Fink | | | | 22. Name and Address of Facility Fink Funeral Home, PA 426 Crain Hwy., SW., Glen Burnie, MD 21061 | | | | |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number D43977 | | 29d. Date signed (Month, Day, Year) November 15 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Angela O'Connell 301 Hospital Drive, Glen Burnie, MD 21061. | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36075

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|---------------------------|---|---|---|---|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Aubrey Lawson</i> | | | | 2. Date of Death Month <i>November</i> Day <i>12</i> Year <i>1999</i> | | | | 3. Time of Death <i>835 pm</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>Maryland General Hospital</i> | | | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number <i>213-07-0771</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>95</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>2/12/04</i> | | 9. Birthplace (State or Foreign Country) <i>N.C.</i> | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State <i>Md.</i> | | 10b. County <i>N/A</i> | | 10c. City, Town or Location <i>Baltimore</i> | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number <i>920 Mt. Holly St.</i> | | | | 10f. Zip Code <i>21229</i> | | 10g. Citizen of What Country? <i>U.S.A.</i> | | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>N/A</i> College (1-4 or 5+) <i>N/A</i> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Silver Maker</i> | | | 16b. Kind of Business/Industry <i>Silver Maker</i> | | | |
| 17. Father's Name (First, Middle, Last) <i>Edward Lawson</i> | | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Dorisey Unknown</i> | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>SARAH Allen (Daughter)</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>920 Mt. Holly St. Baltimore, Maryland 21229</i> | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt. Zion Cemetery</i> | | 20c. Location - City or Town, State <i>Baltimore, Maryland</i> | | 20d. Date <i>11/19/99</i> | | |
| 21. Signature of Funeral Service Licensee <i>Guendel Cromartee</i> | | | | 22. Name and Address of Facility <i>Betts Funeral Home 1129 N. Caroline St. Baltimore, Md. 21213</i> | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>Cardiac Arrhythmia</i> Due to (or as a consequence of):</p> <p>b. <i>Uremia</i> Due to (or as a consequence of):</p> <p>c. <i>Acute Renal Failure</i> Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | 28d. Describe how injury occurred | | | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Dorisey</i> | | | | | 29c. License number <i>89352</i> | | | 29d. Date signed (Month, Day, Year) <i>11/15/99</i> | | |
| 30. Name and address of person who completed cause of death (item 23a) (Type Print) <i>Dorisey Nagar, M.D., 90 Maryland General Hospital</i> | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>NOV 17 1999</i> | | | | 32. Registrar's Signature <i>Sparks</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36076

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|---|---|--|---|--|---------------------------------|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) STEPHANIE FAITH MACDONALD | | | | 2. Date of Death Month Day Year NOVEMBER 13, 1999 | | | | 3. Time of Death 0730 | | |
| | 4a. Facility Name (If not institution, give street and number) 523 KENORA DRIVE | | | | 4b. City, Town, or Location of Death MILLERSVILLE | | | | 4c. County of Death ANNE ARUNDEL | | |
| Funeral Director | 5. Social Security Number 213.50.5716 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 45 Yrs. | | 8. Date of Birth (Month, Day, Year) 1/15/1954 | | 9. Birthplace (State or Foreign Country) MARYLAND | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location MILLERSVILLE | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 523 KENORA DRIVE | | | | 10f. Zip Code 21108 | | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ACCOUNTING SPECIALIST | | | | 16b. Kind of Business/Industry CLOVERLAND GREENSPRING DAIRY | | | |
| 17. Father's Name (First, Middle, Last) WALTER V. HAMMOND | | | | 18. Mother's Name (First, Middle, Maiden Surname) CATHERINE L. SCHUMANN | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) JOSEPH ARTHUR MACDONALD, III | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 523 KENORA DRIVE, MILLERSVILLE, MD 21108 | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEM. PK. | | Date 11/17 | | 20c. Location - City or Town, State GLEN BURNIE, MD | | | |
| 21. Signature of Funeral Service Licensee <i>Kelly Gregory Fink</i> KELLY GREGORY FINK | | | | 22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HWY., SW., GLEN BURNIE, MD 21061 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic Breast Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death 2 yrs. | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Russell DeLuca</i> | | | | 29c. License number 031551 | | | | 29d. Date signed (Month, Day, Year) November 16, 1999 | | | |
| 30. Name and address of person who completed Cause of death (Item 23a) (Type, Print) Russell DeLuca, MD 16005 Crain Highway, Glen Burnie, MD 21061 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | | | 32. Registrar's Signature <i>Beverly S. Sparks</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36077

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond J. Miller, Jr.

2. Date of Death
Month Day Year

Nov. 16 1999

3. Time of Death

4:50AM

4a. Facility Name (If not institution, give street and number)

Pepping Parkway Nursing Center

4b. City, Town, or Location of Death

Parkville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

202-09-6696

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 11, 1918

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3135 Hiss Ave.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

turban operator

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Dr. Raymond J. Miller, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Saunders

19a. Informant's Name/Relationship (Type, Print)

Frederick S. Miller

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2323 Foster Ave. Baltimore, Md 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parkwood Cemetery

Date

Nov. 19
1999

20c. Location - City or Town, State

Parkville Md.

21. Signature of Funeral Service Licensee

Krista S. Wells

22. Name and Address of Facility

Evans Funeral Chapel
8800 Harford Rd. Baltimore, Md 2123423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Pneumonia
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. _____
Due to (or as a consequence of):c. _____
Due to (or as a consequence of):

d. _____

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

dehydration, colon cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Martha C. Raymond MD

29c. License number

D54518

29d. Date signed (Month, Day, Year)

11/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Martha Raymond 3007 E. Northern Pkwy Baltimore, Md.

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

R. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36078

| | | | | | | | | | |
|--|--|---|---|--------------------------------------|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOSEPH MASSUDA | | | | 2. Date of Death Month NOVEMBER Day 11 , Year 1999 | | 3. Time of Death 8:13 PM | | |
| | 4a. Facility Name (If not institution, give street and number) LEVINDALE HEBREW HOME | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 213-60-0017 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) JUL 7, 1922 | | |
| | 9. Birthplace (State or Foreign Country) EGYPT | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 2901 FALLSTAFF ROAD #502 | | | | 10f. Zip Code 21209 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Mental Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PHARMACIST | | 16b. Kind of Business/Industry PHARMACEUTICAL | | | | |
| | 17. Father's Name (First, Middle, Last) ELLIOTT MASSUDA | | | | 18. Mother's Name (First, Middle, Maiden Surname) RACHEL (UNKNOWN) | | | | |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print) LOUISE MASSUDA / WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2901 FALLSTAFF ROAD #502 - BALTIMORE, MD 21209 | | | | |
| | 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON CHIZUK AMUNO | | Date 11/14/99 | | 20c. Location - City or Town, State BALTIMORE, MD | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diabetes Due to (or as a consequence of): Cerebrovascular Disease, Diabetes Mellitus, Atherosclerotic Cardiovascular Disease | | | | | | | Approximate Interval Between Onset and Death days | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Disease, Diabetes Mellitus, Atherosclerotic Cardiovascular Disease | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D33943 | | 29d. Date signed (Month, Day, Year) 11/12/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan M. Levy Levindale | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36079

AMENDED #7PER LFH G777 11/17/99 AH

Certificate of Death

Reg. No.

| | | | | | |
|---|---|---------------------------------|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>ELMIRA MYERS</u> | | 2. Date of Death Month <u>NOVEMBER</u> Day <u>06</u> Year <u>1999</u> | | 3. Time of Death <u>8:22 AM</u> |
| | 4a. Facility Name (If not institution, give street and number) <u>JOHN HOPKINS BAYVIEW MEDICAL CENTER</u> | | 4b. City, Town, or Location of Death <u>BALTIMORE</u> | | 4c. County of Death <u>N/A</u> |
| Funeral Director | 5. Social Security Number <u>215-07-5163</u> | 6. Sex <u>1</u> M <u>2</u> F | 7. Age (In yrs. last birthday) <u>81</u> Yrs. | 8. Date of Birth (Month, Day, Year) <u>JULY 28, 1911</u> | 9. Birthplace (State or Foreign Country) <u>MD.</u> |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State <u>MD.</u> | 10b. County <u>BALTIMORE</u> | 10c. City, Town or Location <u>N/A</u> | | 10d. Inside City Limits <u>1</u> Yes <u>2</u> No |
| | 10e. Street and Number <u>1911 DUNDALK AVE.</u> | | 10f. Zip Code <u>21222</u> | | 10g. Citizen of What Country? <u>USA</u> |
| | 11. Marital Status <u>3</u> Widowed <u>4</u> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) <u>1</u> Yes <u>2</u> No |
| | 14. Race - American Indian, Black, White, etc. <u>WHITE</u> | | 15. Decedent's Education (Specify only highest grade completed) <u>UKN.</u> | | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>TAILOR</u> | | 16b. Kind of Business/Industry <u>SEWING</u> | | |
| | 17. Father's Name (First, Middle, Last) <u>RAYMOND MANCUSO</u> | | 18. Mother's Name (First, Middle, Maiden Surname) <u>MARY MONTALTO</u> | | |
| | 19a. Informant's Name/Relationship (Type, Print) <u>LOUISE DUDA/SISTER</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1911 DUNDALK AVE., BALTIMORE, MD. 21222</u> | | |
| | 20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>OAK LAWN CEMETERY</u> | | 20c. Location - City or Town, State <u>BALTIMORE, MD.</u> |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee <u>Charles S. Zeiler</u> | | 22. Name and Address of Facility <u>CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224</u> | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| | Immediate Cause (Final disease or condition resulting in death) a. <u>RUPTURED ABDOMINAL AORTIC ANEURYSM</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown | | | | |
| | 24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No | | 24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No | | |
| | 25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No | | | | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one) Hospit: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) | | | | |
| | 27. Manner of Death <u>1</u> Natural <u>2</u> Accident <u>3</u> Suicide <u>4</u> Homicide <u>5</u> Pending investigation <u>6</u> Could not be determined | | 28a. Date of Injury (Month, Day, Year) <u>NOV 17 1999</u> | | 28b. Time of Injury <u>M</u> |
| | 28c. Injury at Work? <u>1</u> Yes <u>2</u> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <u>1</u> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier <u>Mark D. Duncan, M.D., DEPT. OF SURGERY</u> | | 29c. License number <u>D51298</u> | | 29d. Date signed (Month, Day, Year) <u>NOVEMBER 6, 1999</u> |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>MARK D. DUNCAN, M.D., DEPT. OF SURGERY, JOHN HOPKINS BAYVIEW MEDICAL CENTER, BALTIMORE, MD 21224</u> | | | | |
| | 31. Date filed (Month, Day, Year) <u>NOV 17 1999</u> | | | | |
| State Registrar | 32. Registrar's Signature <u>Geneva S. Sparks</u> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

copy of [unclear] [unclear]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36080

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Carolyn C. Nemecek

2. Date of Death

November 15, 1999

3. Time of Death

12:25 p.m.

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

214-38-4460

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Aug. 23, 1940

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baldwin

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3109 Brandon Hunt Lane

10f. Zip Code

21013

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Development Asst.

16b. Kind of Business/Industry

Maryvale Prep

17. Father's Name (First, Middle, Last)

William R. Carter

18. Mother's Name (First, Middle, Maiden Summa)

Sallie A. Wilson

19a. Informant's Name/Relationship (Type, Print)

C. Robert Nemecek - Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3109 Brandon Hunt Lane Baldwin, Maryland 21013

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

Nov. 19, 1999

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Heather Caen

22. Name and Address of Facility

Evans Chapel of Memories
8800 Hartford Road
Baltimore, Maryland 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Endometrial Cancer

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Colon Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Tariq Mahmood

29c. License number

D43725

29d. Date signed (Month, Day, Year)

11/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Tariq Mahmood, 2300 Dulany Valley Road, Timonium, MD 21093

State
Registrar

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

Benita B. Sparks

November 15, 1999 12:25 p.m.

Baltimore, Maryland 21215-0020

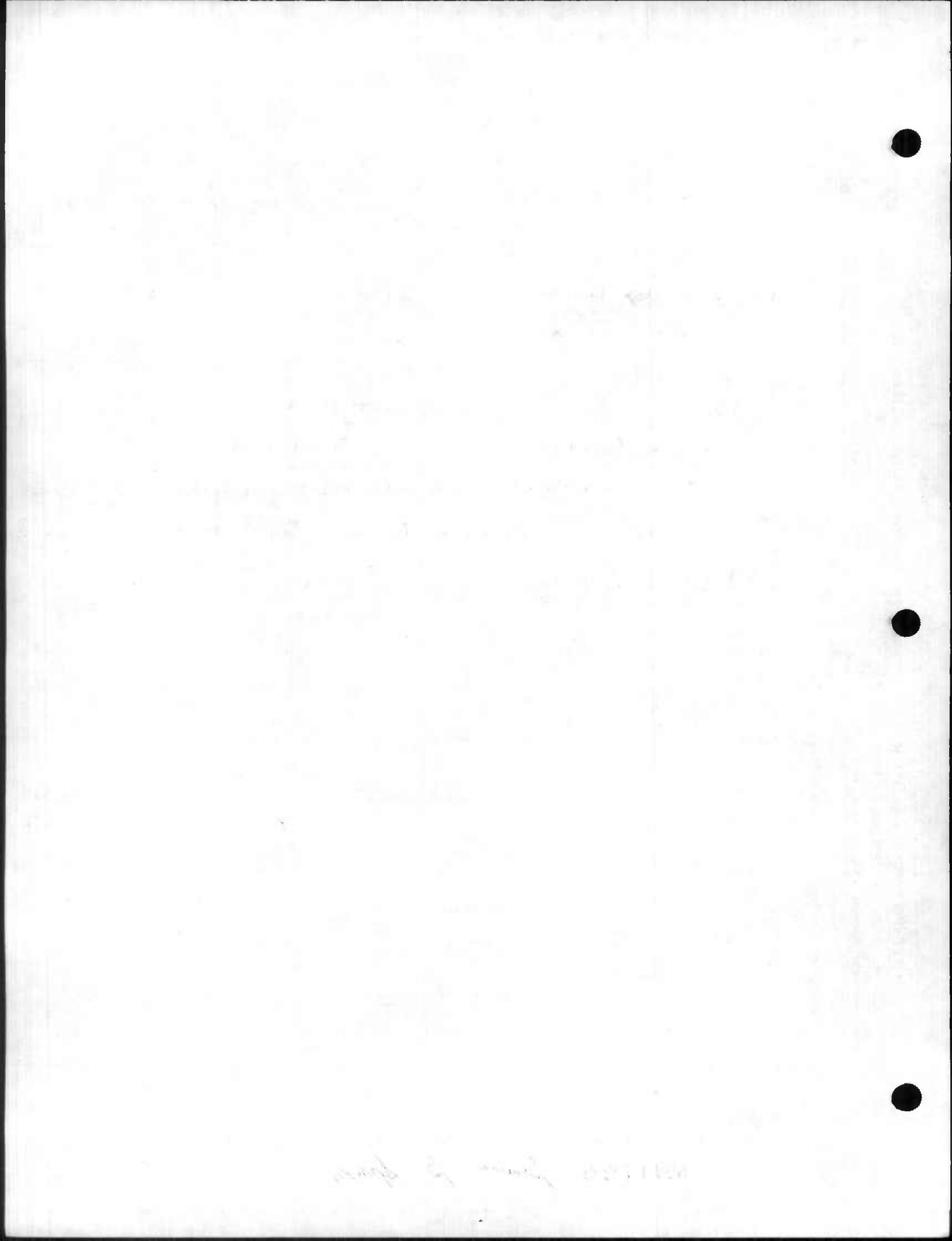
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Nemecek, Carolyn

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36081

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

TINNER

2. Date of Death

Month Day Year
NOVEMBER 13, 1999

3. Time of Death

08:30

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N. A

Funeral
Director

5. Social Security Number

214 26 3532

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
9/12/12

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10e. State

Md.

10b. County

N A

10c. City, Town or Location

BALTO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1706 N. CAROLINE ST

10f. Zip Code

21212

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MAINTENANCE

16b. Kind of Business/Industry

B. G. & E. Co.

17. Father's Name (First, Middle, Last)

ARCHIE JAMES

18. Mother's Name (First, Middle, Maiden Surname)

ELIZA FORD

19a. Informant's Name/Relationship (Type, Print)

HILDA D. JAMES

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1706 N. CAROLINE ST BALTO. MD 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTO Cem

Date

11/18/99

20c. Location - City or Town, State

BALTO. MD

21. Signature of Funeral Service Licensee

Joseph B. Locks Jr.

22. Name and Address of Facility

Joseph B. Locks Jr. 3/4 1304 N. Central Ave

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

2 WEEKS

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

2 WEEKS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David Z. Z. MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

NOVEMBER 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID Z. Z. MD, JOHNS HOPKINS HOSPITAL, BALTIMORE, MARYLAND 21287

State
Registrar

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

David B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36082

| | | | | | | | | | | |
|--|--|---|---|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HELEN C. PARLAMAN | | | | 2. Date of Death Month Day Year NOVEMBER 15, 1999 | | | | 3. Time of Death 6:30 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) 50 CHESAPEAKE MOBILE COURT | | | | 4b. City, Town, or Location of Death HANOVER | | | | 4c. County of Death ANNE ARUNDEL | |
| Funeral Director | 5. Social Security Number 236-56-8423 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 63 Yrs. | | 8. Date of Birth (Month, Day, Year) APRIL 13, 1936 | | 9. Birthplace (State or Foreign Country) WEST VIRGINIA | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location HANOVER | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 50 CHESAPEAKE MOBILE CT. | | | | 10f. Zip Code 21076 | | 10g. Citizen of What Country? UNITED STATES | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | | 16b. Kind of Business/Industry OWN HOME | | | |
| | 17. Father's Name (First, Middle, Last) HENRY SCOTT COTTRELL | | | | | 18. Mother's Name (First, Middle, Maiden Surname) FLORENCE LYNELLE JOHNSON | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) CATHERINE R. BEATTY / DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1626 RIVERDALE DRIVE, EDGEWATER, MARYLAND 21037 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEM. PK. | | Date NOV. 18 1999 | | 20c. Location - City or Town, State ELKRIDGE, MARYLAND | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION | | | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier  | | | | 29c. License number D 25559 | | 29d. Date signed (Month, Day, Year) NOV. 16, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAWRENCE VIDAVER, M.D., 420 CRAIN HWY., SW, SUITE 3, GLEN BURNIE, MD 21061 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature  | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36083

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|---|---|------------------------------|--|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|----------------|-------------------|--|--|--|--|--|--|--|--------------|----------------------------------|--|--|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ANNE M. PRIES | | | | 2. Date of Death Month 11 Day 15 Year 1999 | | | | 3. Time of Death 10:30 PM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 566 WEST UNIVERSITY PARKWAY | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 213-44-9530 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 58 Yrs. | | 8. Date of Birth (Month, Day, Year) 06-19-1941 | | 9. Birthplace (State or Foreign Country) MARYLAND | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. State MD. | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE CITY | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10e. Street and Number 566 WEST UNIVERSITY PARKWAY | | | | 10f. Zip Code 21210 | | | | 10g. Citizen of What Country? U.S.A. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE | | | | 16b. Kind of Business/Industry OWN HOME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) OLIVER JACKSON MARSTON | | | | 18. Mother's Name (First, Middle, Maiden Surname) ELEANOR MacDONALD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) JOHN S. GIBBS (COUSIN) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 NORTHWAY, BALTIMORE, MARYLAND, 21212 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GREEN MOUNT CREMATORY | | 20c. Location - City or Town, State 11-18 BALTO., MD., 21202 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility HENRY W. JENKINS AND SONS COMPANY 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="8">MYOCARDIAL INFARCTION</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> <td>MINUTES</td> </tr> <tr> <td colspan="8">A.S.C.V.D.</td> <td>YEARS</td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="8">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | MYOCARDIAL INFARCTION | | | | | | | | Approximate Interval Between Onset and Death | Due to (or as a consequence of): | | | | | | | | MINUTES | A.S.C.V.D. | | | | | | | | YEARS | Due to (or as a consequence of): | | | | | | | | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): | | | | | | | | | Due to (or as a consequence of): | | | | | | | | | Due to (or as a consequence of): | | | | | | | | | Due to (or as a consequence of): | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | MYOCARDIAL INFARCTION | | | | | | | | Approximate Interval Between Onset and Death | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | MINUTES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | A.S.C.V.D. | | | | | | | | YEARS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERIPHERAL VASCULAR DISEASE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number 00009433 | | | | 29d. Date signed (Month, Day, Year) NOVEMBER 16, 1999 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM H. SPENCER-STRONG, M.D., 7801 YORK ROAD, TOWSON, MARYLAND, 21204 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | | | 32. Registrar's Signature  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AH

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

99 36004

Certificate of Death

Reg. No.

| | | | | | |
|---|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GENEVA PATTON | | 2. Date of Death Month Day Year NOVEMBER 10, 1999 | | 3. Time of Death 5:10 PM |
| | 4a. Facility Name (If not institution, give street and number) 2107 W. FAYETTE STREET | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 218-28-5439 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 66 Yrs. | 8. Date of Birth (Month, Day, Year) JAN. 29, 1933 | 9. Birthplace (State or Foreign Country) MARYLAND |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | 10b. County N/A | 10c. City, Town or Location BALTIMORE CITY | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number 2107 W. FAYETTE STREET | | 10f. Zip Code 21223 | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 + HIGHER College (1-4 or 5+) 2 YRS | | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CARE PROVIDER | | 16b. Kind of Business/Industry STATE HOSPITAL | | |
| | 17. Father's Name (First, Middle, Last) ROY CLIFTON YOUNGER | | 18. Mother's Name (First, Middle, Maiden Surname) WILLIE ESTHER TISDALE | | |
| | 19a. Informant's Name/Relationship (Type, Print) KELITA FIELD (DAUGHTER) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 S. CATHERINE ST. BALTIMORE, MD. 212 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY | | 20c. Location - City or Town, State 11-16-99 LANSDOWNE, MD. |
| Physician /Medical Examiner | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIMORE, MD. 21217 | | |
| | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| | Immediate Cause (Final disease or condition resulting in death) a. squamous cell lung cancer Due to (or as a consequence of): | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| State Registrar | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier | | 29c. License number D052133 | | 29d. Date signed (Month, Day, Year) November 15, 1999 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beverly Drucker MD 600 North Wolfe Street Baltimore Maryland 21287 | | | | |
| | 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Janice Ann Rosenzweig

2. Date of Death

November 15, 1999 20:09

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

220-52-3540

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 23, 1950

9. Birthplace (State or Foreign Country)

Baltimore, Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6351 Red Cedar Place

10f. Zip Code

21209-3830

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

07

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Attorney

16b. Kind of Business/Industry

Health Care Law

17. Father's Name (First, Middle, Last)

Bernard Popick

18. Mother's Name (First, Middle, Maiden Surname)

Harlee Sidell Senzer

19a. Informant's Name/Relationship (Type, Print)

Mr. Norman Rosenzweig(Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6351 Red Cedar Place Baltimore, Maryland 21209-3830

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corporation

Date

11/18/1999

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

Jeffrey L. Gair

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204-2515

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or renal failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery occlusion by septic thrombus

terminal

Due to (or as a consequence of):

b. Septic vegetation of the prosthetic aortic valve

Days

Due to (or as a consequence of):

c. Repeated infections with methicillin resistant staph

1 year

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary hypertension

Gaucher's disease

Status-post total left hip replacement

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Howard L. Siegel

29c. License number

D28885

29d. Date signed (Month, Day, Year)

11/16/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard L. Siegel, M.D. - GBMC 6701 N Charles St., Baltimore MD 21204

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

James B. Sparks

State
Registrar

Rosenzweig, Janice

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician
/Medical
Examiner

1914

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elaine Rudow

2. Date of Death

November 15 1999

3. Time of Death

12:40 PM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

219-30-3040

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

MAY 16, 1933

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

ONE SWANHILL DRIVE

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collega (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

REUBEN

CHESLER

18. Mother's Name (First, Middle, Maiden Surname)

SARAH

ZUCKER

19a. Informant's Name/Relationship (Type, Print)

MAURICE G. RUDOW / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

ONE SWANHILL DRIVE - BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH EL MEMORIAL PARK

Date

11/16/99

20c. Location - City or Town, State

RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis
Due to (or as a consequence of):

b. Pneumonia - methicillin resistant staphylococcus aureus
Due to (or as a consequence of):

c. Metastatic breast cancer to lung, bone, skull
Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia

Thrombocytopenia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

P13207

29d. Date signed (Month, Day, Year)

November 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sinai Hospital of Baltimore 2401 West Belvedere Avenue Baltimore, MD 21215

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36087

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Susan

Safak

2. Date of Death
Month Day Year
November 13 1999

3. Time of Death
3:35 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

212-82-5813

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

40 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

7-18-1959

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

313 Milton Avenue

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Legal Secretary

16b. Kind of Business/Industry

Law

17. Father's Name (First, Middle, Last)

Walter m. Lamar

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Whitehead

19a. Informant's Name/Relationship (Type, Print)

Sametia Safak - hus.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

313 Milton Avenue, Glen Burnie Md 21061

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

11-16

20c. Location - City or Town, State

Baltimore Md

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Link funeral Home, PA
426 Crain Hwy. SW Glen Burnie Md 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Breast Carcinoma

Approximate Interval Between Onset and Death

4 Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] House Physician

29c. License number

D53642

29d. Date signed (Month, Day, Year)

Nov. 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

X/AOM 2104 301 Hospital drive Glen Burnie M.O. 21061

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

[Signature]

State
Registrar

Safak, Susan

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-0000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36088

amend item 1 per phys. G781 3/1/00 yg

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marta Aquino Simon

2. Date of Death

Month Day Year

November 12, 1999

3. Time of Death

6:25AM.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

UNKNOWN

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 30, 1930

9. Birthplace (State or Foreign Country)

Philippines

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3110 Putty Hill Avenue

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Phillipino

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

E.R. Beltran

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14 Candlelight Ct. Timonium, Maryland 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Gar.

Date

Nov. 15, 1999

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Heather Cain

22. Name and Address of Facility

Evans Chapel of Memories
8800 Harford Rd.
Baltimore, MD 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolus

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 Minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier

William Frohna

29c. License number

D0054103

29d. Date signed (Month, Day, Year)

November 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. William Frohna 9000 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)

Nov 17 1999

32. Registrar's Signature

Sparks

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36089

Amended Item#1perPhy.#5 perFHG778 12/28/99 EW

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|---|--|--|--|--|---|--------------------------------|--|--------------------------------|---|--|
| Physician/ Medical Examiner | 1. Decedent's Name (First, Middle, Last) Young Chul Shin | | | | 2. Date of Death Month Day Year November 3, 1999 | | | | 3. Time of Death 4:15 AM | | |
| | 4e. Facility Name (If not institution, give street and number) Maryland General Hospital | | | | 4b. City, Town, or Location of Death Baltimore City | | | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 214-33-4246 UNK | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (in yrs. last birthday) 85 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | |
| | 8. Date of Birth (Month, Day, Year) MAY 1, 1914 | | 9. Birthplace (State or Foreign Country) Korea | | Usual Residence of Decedent | | 10a. State MD | | 10b. County Baltimore | | |
| 10c. City, Town or Location Perry Hall | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10a. Street and Number 11 Fox Brier Lane | | 10f. Zip Code 21236 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Korean | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pharmacist | |
| 16b. Kind of Business/Industry Medical | | 17. Father's Name (First, Middle, Last) (Unknown) | | 18. Mother's Name (First, Middle, Maiden Surname) (Unknown) | | 19a. Informant's Name/Relationship (Type, Print) Sang Tae Ahn - son-in-law | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Fox Brier Lane, Baltimore, Md. 21236 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Pk. | | Date 11/6/99 | | 20c. Location - City or Town, State Elkridge, Md. | | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075 | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Gastric Carcinoma Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Arun Chandor MD | | 29c. License number 89346 | | 29d. Date signed (Month, Day, Year) 11/13/99 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Arun Chandor, M.D. 40 Maryland General Hospital. | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature B. Sparks | | State Registrar | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Amended Item#7 perFH G777 11/17/99 EW

99 36090

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George D. Singer

2. Date of Death
Month

Day 13 Year 99

3. Time of Death

12:45 AM

4a. Facility Name (If not institution, give street and number)

Keeswick

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

578-05-6407

6. Sex

1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday)

92 92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

07-14-1907

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3601 CLARKS LANE APT#522

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+4 YEARS

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PHARMACIST

16b. Kind of Business/Industry

PHARMACY

17. Father's Name (First, Middle, Last)

MORRIS

SINGER

18. Mother's Name (First, Middle, Maiden Surname)

MOLLIE

POLAN

19e. Informant's Name/Relationship (Type, Print)

MRS. RENA SINGER -WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3601 CLARKS LANE APT. #522 BALTO., MD 21215

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SHAAREI ZION CONG. - ROSEDALE

Date

11/15/99

20c. Location - City or Town, State

BALTO. CO. MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SOL LEVINSON BROS., INC.

8900 REISTERSTOWN ROAD BALTO., MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, aneurysm, failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PROGRESSIVE GUARDIANSHIP Palsy

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

J12399

29d. Date signed (Month, Day, Year)

November 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES D. JORDAN III, MD Keeswick 700 W. 40th St BALTIMORE, MD 21211

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36091

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN WILLIAM SCHARDT

2. Date of Death

Month Day Year
11 15 1999

3. Time of Death

7:36 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

HAMMONDS LANE GENESIS ELDERCARE CENTER

4b. City, Town, or Location of Death

BROOKLYN PARK

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

198-201-1004

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
OCT. 14, 1927

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18 GREENWOOD RD.

10f. Zip Code

21061

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: '45-'4713. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

POSTAL EMPLOYEE

16b. Kind of Business/Industry

U.S. POSTAL SERVICE

17. Father's Name (First, Middle, Last)

HERBERT PATRICK SCHARDT

18. Mother's Name (First, Middle, Maiden Sumama)

VIOLA B. PUTNAM

19a. Informant's Name/Relationship (Type, Print)

WILLIAM L. SCHARDT / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1806 ST. MARGARETS RD., ANNAPOLIS, MD 21401

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) ENTOMBMENT20b. Place of Disposition (Name of
cemetery, crematory or other place)

CEDAR HILL CEMETERY

Date

NOV. 17
1999

20c. Location - City or Town, State

BROOKLYN PARK, MARYLAND

21. Signature of Funeral Service licensee

[Signature]

22. Name and Address of Facility

KIRKLEY-RUDDICK FUNERAL HOME, P.A.

421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Hypoxemia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 day

b. Metastatic Bladder Cancer

Due to (or as a consequence of):

1 month

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Chronic Obstructive Pulmonary Disease 5 years

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation 6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

DS3462

29d. Date signed (Month, Day, Year)

11/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2112 Belair Road Suite 9 Fallston, MD 21047

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

[Signature] G. Sparks

State
Registrar

Schardt, John

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36092

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HILDA THOMAS

2. Date of Death

Month
11Day
14Year
99

3. Time of Death

1230pm

4a. Facility Name (If not institution, give street and number)

ALICE MANOR N.H.

4b. City, Town, or Location of Death

BALTO.

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

178-24-9592

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
12-4-08

9. Birthplace (State or Foreign Country)

UNKNOWN

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2095 ROCKROSE AVE.

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
UNKNOWN

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SEAMSTRESS

16b. Kind of Business/Industry

FACTORY

17. Father's Name (First, Middle, Last)

ALBERT I. MARTIN

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

COM. ON AGING MS. ALEXANDER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

34 MARKET PLACE #302 BALTO. MD. 21202

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. CARMEL CEM

Date

N/A

20c. Location - City or Town, State

BALTO. MD.

21. Signature of Funeral Service Licensee

Thomas J. Akanda

22. Name and Address of Facility

SKARDA FH. 2829 HUDSON ST. BALTO. MD. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

End Stage Alzheimer's

Due to (or as a consequence of):

Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Depression

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

H. Devadoss M.D.

29c. License number

D-20146

29d. Date signed (Month, Day, Year)

11-15-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HEMALATA DEVADOSS M.D. 2095 Rockrose ave. Balto Md. 21211

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36093

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William James Smith

2. Date of Death

Month Day Year
NOVEMBER 13 1999 5:10 AM

3. Time of Death

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Stella Maris Hospice at Mercy

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

219-22-3270

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

8-27-27

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4014 Cedar Dale Road

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 11/1/45-2/4/47

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Retail Clerk

16b. Kind of Business/Industry

Bain Shop, Shop & Save

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Summa)

Mattie Smith

19a. Informant's Name/Relationship (Type, Print)

Daphne Smith / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4014 Cedar Dale Road, Baltimore, MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carrington Forest VA Cem.

Date

11/18/99

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Harris P. Rose Funeral Service
709 Tension St., Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Traumatic Cerebral Contusion after fall

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic Brain Tumor

S/P Right Lobectomy - unknown cause

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

November 6, 1999

28b. Time of Injury

11:00 AM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

The subject fell

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4014 Cedar Dale Road, Baltimore, Maryland

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 40854

29d. Date signed (Month, Day, Year)

NOVEMBER 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID RISEBERG 301 St Paul Pl., BALTIMORE MD 21202

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

[Signature]

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

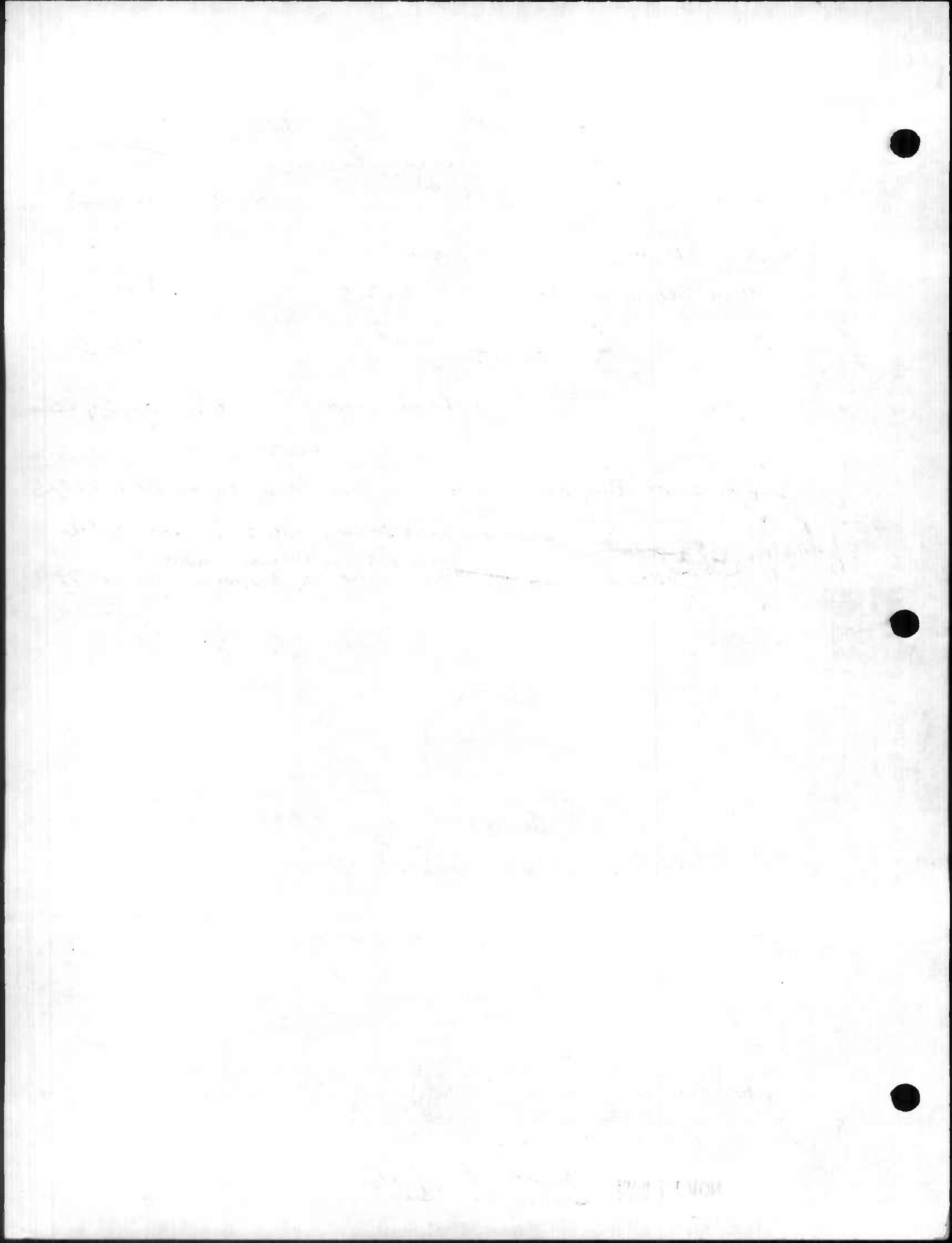
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36094

| | | | | | | | | | |
|--|---|---|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) RICHARD SCOTT | | | | 2. Date of Death Month Day Year NOVEMBER 13, 1999 | | 3. Time of Death 7:57 AM | | |
| | 4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death RANDALLSTOWN | | 4c. County of Death BALTIMORE | | |
| Funeral Director | 5. Social Security Number 215-16-1374 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 77 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) FEB. 04, 1922 | 9. Birthplace (State or Foreign Country) SOUTH CAROLINA | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | 10b. County NIA | | 10c. City, Town or Location BALTIMORE CITY | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 15 LIBERTY PLACE ROAD, APT. 5 | | | | 10f. Zip Code 21244 | | 10g. Citizen of What Country? USA. | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CAR INSPECTOR | | 16b. Kind of Business/Industry RAILROAD COMPANY | | | | |
| | 17. Father's Name (First, Middle, Last) WILLIAM HENRY SCOTT SR | | | | 18. Mother's Name (First, Middle, Maiden Surname) ANGRONIE SAUNDERS | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) ATLANTA SCOTT (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 LIBERTY PLACE ROAD, APT. 5, BALTIMORE, MD. 21244 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) PARKWOOD CEMETERY 11-18-99 | | 20c. Location - City or Town, State BALTIMORE, MARYLAND | | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIMORE, MD. 21217 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. HYPERTENSIVE CARDIOVASCULAR DISEASE Due to (or as a consequence of): c. DIABETES MELLITUS Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death 1 HOUR YEARS YEARS | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC RENAL FAILURE | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D47587 | | 29d. Date signed (Month, Day, Year) NOVEMBER 13, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT F. NEASE 5401 OLD COURT ROAD, RANDALLSTOWN, MD 21133 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

STEVEN G. STRICKLIN

AMEND: 1. PER MEO G778 State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F

Certificate of Death

Reg. No.

99 36095

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|---|--|---|---|---|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Steven G. Strickland</u> STEVEN G. STRICKLIN | | | | 2. Date of Death Month Day Year NOVEMBER 12, 1999 | | 3. Time of Death 1220 PM |
| | 4a. Facility Name (If not institution, give street and number) NORTHPOINT LIQUOR STORE - PARKING LOT | | | | 4b. City, Town, or Location of Death DUNDALK | | 4c. County of Death BALTIMORE |
| Funeral Director | 5. Social Security Number 216-56-9302 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 40 Yrs. | 8. Under 1 Year Months Days | 9. Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 03-20-1959 | 9. Birthplace (State or Foreign Country) Md. |
| | Usual Residence of Decedent | | | | | | |
| 10e. State Md. | | 10b. County Baltimore | | 10c. City, Town or Location Dundalk | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 6830 Belclare Rd. | | | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tree Trimmer | | 16b. Kind of Business/Industry Tree Expert | |
| 17. Father's Name (First, Middle, Last) <u>VERON E. STRICKLIN</u> Vernon F. Strickland | | | | 18. Mother's Name (First, Middle, Maiden Surname) Agnes Pötter | | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>Agnes Strickland/Mother</u> Agnes Stricklin | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6830 Belclare Rd., Dundalk, Md. 21222 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) OakLawn Cemetery | | Data 11-17-99 | | 20c. Location - City or Town, State Balto., Md. | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Bradley-Ashton-Matthews, Inc. 2134 Willow Spring Rd., Balto., Md. 21222 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE ETHANOL & NARCOTIC INTOXICATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) Found: 11-12-99 | | 28b. Time of Injury Found: 11:15 | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how injury occurred UNKNOWN | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) 3838 NORTHPOINT BLVD. DUNDALK, MD | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) NOVEMBER 12, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 PENN STREET BALTIMORE, MARYLAND 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36096

| | | | | | | | | |
|--|---|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GERARD Wilbur SPANN | | | | 2. Date of Death Month NOVEMBER Day 13 Year 1999 | | 3. Time of Death 12:08 A | |
| | 4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 214-86-5661 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 28 Yrs. | | 8. Date of Birth (Month, Day, Year) 12/1/70 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Forklift operator | | 16b. Kind of Business/Industry CPA | | 17. Father's Name (First, Middle, Last) Walter Vice | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Patricia Spann | | 19a. Informant's Name/Relationship (Type, Print) Patricia Spann (mother) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5956 DAYWALT AVE #K Baltimore, MD 21206 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery | | 20c. Date 11/17/99 | | 20d. Location - City or Town, State Baltimore, Maryland | | 21. Signature of Funeral Service Licensee Guendel Cromartie | | |
| 22. Name and Address of Facility Betts Funeral Home | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple Gunshot Wounds | | 23b. Approximate Interval Between Onset and Death | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) 11-12-99 | | 28b. Time of Injury 2332p M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred subject shot | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2000 Block Oliver Street Baltimore, Md | | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | |
| 29b. Signature and title of certifier Dennis J. Chute, MD | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) NOVEMBER 13, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, MD | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature [Signature] | | 33. State Registrar 111 Penn Street, Baltimore, Maryland 21201 | | 34. State Registrar NOV 17 1999 | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36097

AMENDED ITEM #20b & 20c PER FH G777 11/19/99 AH

| | | | | | | | | |
|--|--|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Nettie Trodgen | | | | 2. Date of Death Month Day Year Nov. 15, 99 | | 3. Time of Death 10:20am | |
| | 4a. Facility Name (If not institution, give street and number) Lorien Frankford Nursing Home | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NA | |
| Funeral Director | 5. Social Security Number 215-18-3992 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) 08-14-14 | |
| | 9. Birthplace (State or Foreign Country) SC | | 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 5009 Frankford Avenue | | 10f. Zip Code 21206 | | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) 8th Grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria Worker | | 16b. Kind of Business/Industry Company | | |
| 17. Father's Name (First, Middle, Last) John Woodard | | 18. Mother's Name (First, Middle, Maiden Summa) Hanna Jenkins Apt#202 | | 19a. Informant's Name/Relationship (Type, Print) Martha Britton | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202 1508 Harford Avenue Baltimore, Maryland | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN CEMETERY | | 20c. Location - City or Town, State WOODLAWN, MD | | 20d. Date 11-19-99 | | |
| 21. Signature of Funeral Service Licensee Francis [Signature] | | 22. Name and Address of Facility Baltimore, Maryland 21202 | | 22a. Name and Address of Facility WM. C. March FH 1101 E. North Avenue | | 22b. Name and Address of Facility Baltimore, Maryland 21202 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia (LLL) Due to (or as a consequence of): ADVANCED ALZHEIMER'S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last ASCVD; PVD; BILATERAL AAA's; CVA C DISSEMINATED G-TUBE; ANEMIA; OSTEOPOROSIS | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 24. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 26. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 27. Date of Injury (Month, Day, Year) 11-19-99 | | |
| 28a. Time of Injury M | | 28b. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28c. Describe how injury occurred | | 28d. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier [Signature] M.D. | | 29c. License number 041291 | | 29d. Date signed (Month, Day, Year) 11-16-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JENNIFER GUTTER, MD, 2100 S. MARYLAND AVE, BALTIMORE, MD 21202 | | 31. Data filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature [Signature] | | 33. Registrar's Name JOHN J. GUTTER, JR. | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36098

| | | | | | | | | |
|---|---|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Jeanette Tyson</i> | | | | 2. Date of Death Month <i>November</i> Day <i>12</i> Year <i>1999</i> | | 3. Time of Death <i>4:37 A</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>The Johns Hopkins Hospital</i> | | | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | 4c. County of Death <i>NA</i> | |
| Funeral Director | 5. Social Security Number <i>214-86-6399</i> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>33</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>07-21-66</i> | |
| | 9. Birthplace (State or Foreign Country) <i>MD</i> | | 10a. State <i>MD</i> | | 10b. County <i>NA</i> | | 10c. City, Town or Location <i>Baltimore</i> | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number <i>1010 Rutland Avenue</i> | | 10f. Zip Code <i>21205</i> | | |
| 10g. Citizen of What Country? <i>USA</i> | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th Grade</i> College (1-4 or 5+) <i>NA</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Unemployed</i> | | 16b. Kind of Business/Industry <i>Never-worked</i> | | |
| 17. Father's Name (First, Middle, Last) <i>Charles E. Harris</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Peggy Tyson</i> | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Peggy Bess</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3112 Stancil Place Charlotte NC 28211</i> | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Voshell Mem. Gardens</i> | | 20c. Location - City or Town, State <i>11-17-99 Dundalk, MD</i> | | 20d. Date | | |
| 21. Signature of Funeral Service Licensee <i>Francis G...</i> | | | | 22. Name and Address of Facility <i>Baltimore, Maryland 21202</i> <i>WM.C.March FH 1101 E. North Avenue</i> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Upper gastrointestinal hemorrhage</i> Due to (or as a consequence of): <i>b. gastritis due to alcoholism</i> Due to (or as a consequence of): <i>c.</i> Due to (or as a consequence of): <i>d.</i> Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| Approximate Interval Between Onset and Death <i>3 hours</i> <i>1 year</i> | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Retroviral illness</i> | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 28g. | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Marcus Cooper, M.D.</i> | | | | 29c. License number <i>RES-000</i> | | 29d. Date signed (Month, Day, Year) <i>November 12, 1999</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Marcus Cooper JOHNS HOPKINS HOSPITAL 600 North Wolfe Street, Baltimore, MD 21287</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>NOV 17 1999</i> | | | | 32. Registrar's Signature <i>Benjamin Sparks</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

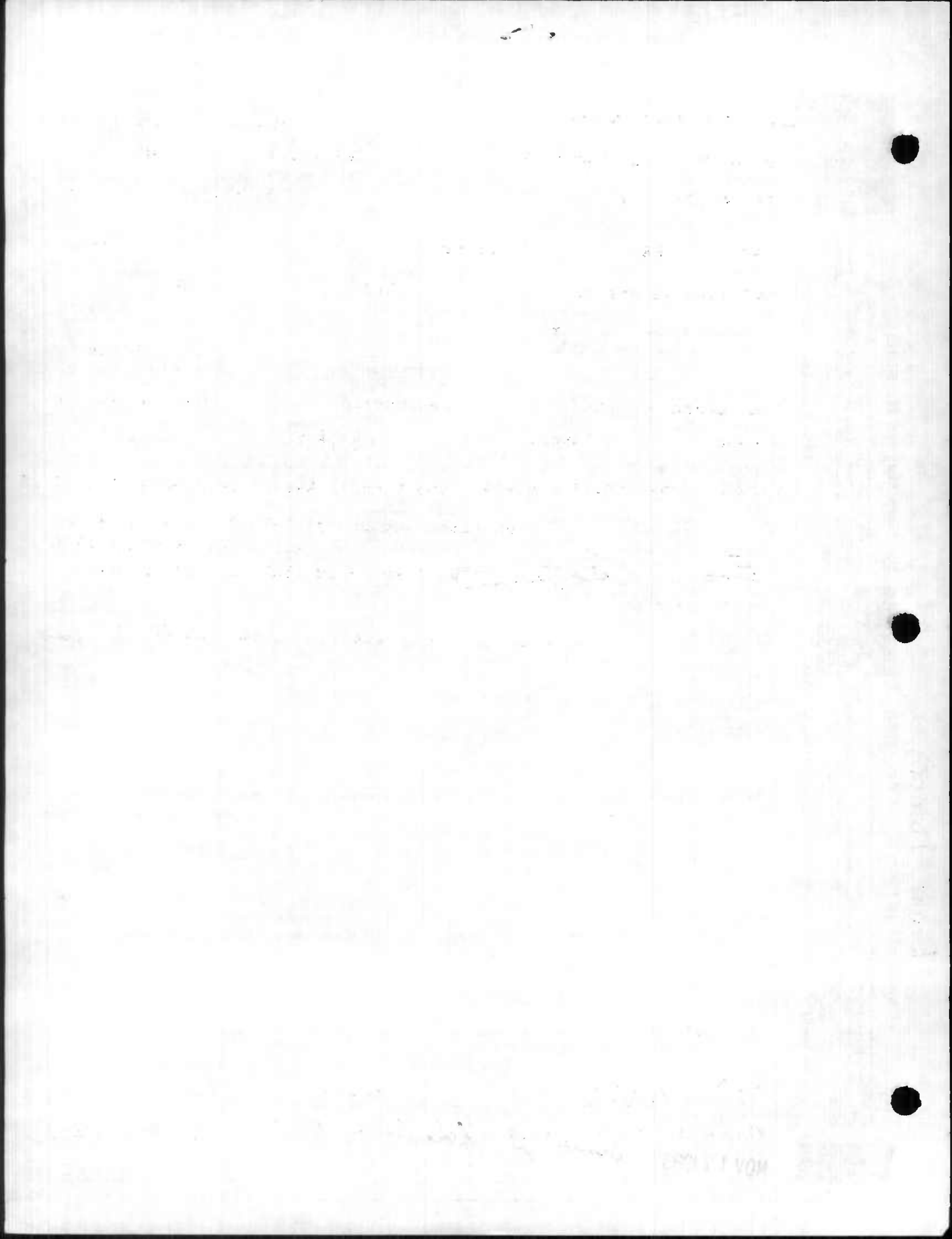
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36099

| | | | | | | | | |
|--|--|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Lewis Junior Turner | | | | 2. Date of Death Month November Day 14 Year 1999 | | 3. Time of Death 0707 AM | |
| | 4a. Facility Name (If not institution, give street and number) Union Memorial Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NA | |
| Funeral Director | 5. Social Security Number 226-14-1381 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) 06-18-18 | |
| | 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 1403 Kenhill Avenue | | | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2nd. Grade College (1-4 or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction | | 16b. Kind of Business/Industry Construction Co. | | |
| 17. Father's Name (First, Middle, Last) Ernest Turner | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lellia Harden | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Lillie Turner & Lucille Lewis | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1403 Kenhill Avenue Baltimore, MD. 21213 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Cemetery | | 20c. Location - City or Town, State 11-18-99 Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer with bone metastases - Non Small Cell 3mo. Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) 11-18-99 | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. Signature and title of certifier  Davis M. Hahn MD |
| 29c. License number D20396 | | | | 29d. Date signed (Month, Day, Year) November 14, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Davis M. Hahn 5804 Lyndale Avenue Blvd, Balt. Md 21239 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36100

TALKING TOP, WOODROW

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

| | | | |
|-----------------------------------|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Woodrow Wilson Talkington | 2. Date of Death Month Day Year NOVEMBER 14, 1999 | 3. Time of Death 4:32 P.M. |
| | 4e. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER | 4b. City, Town, or Location of Death ROSEDALE | 4c. County of Death BALTIMORE |
| Funeral Director | 5. Social Security Number 235-14-8857 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. |
| | 8. Date of Birth (Month, Day, Year) SEPT. 6, 1914 | 9. Birthplace (State or Foreign Country) West Virginia | |

To Be Completed by Funeral Director

| | | | |
|---|--|--|--|
| 10a. State MD | 10b. County Baltimore | 10c. City, Town or Location Dundalk | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 10e. Street and Number 8142 Kavanaugh Rd. | | 10f. Zip Code 21222 | 10g. Citizen of What Country? USA |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | 14. Race - American Indian, Black, White, etc. Specify: white |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter | 16b. Kind of Business/Industry Construction |
| 17. Father's Name (First, Middle, Last) Joseph Talkington | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Bice | |
| 19a. Informant's Name/Relationship (Type, Print) Betty Clift - daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8142 Kavanaugh Rd., Baltimore, Md. 21222 | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park | Date 11/18/99 | 20c. Location - City or Town, State Elkridge, Md. |
| 21. Signature of Funeral Service Licensee Louis L. Hunt M00257 | | 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075 | |

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | |
|---|---|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. END STAGE RENAL FAILURE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death 24 HOURS | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANEMIA, DEMENTIA, NON Q WAVE MYOCARDIAL INFARCTION | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. Signature and title of certifier W. Rose | 29c. License number 045789 | 29d. Date signed (Month, Day, Year) 11/14/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. WILBUR ROSE 9000 FRANKLIN SQUARE DR BALTO, MD 21237 | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | 32. Registrar's Signature Benjamin S. Sparks | | |

Robert Truitt AMEND ITEM: 14 State of Maryland / Department of Health and Mental Hygiene
AMEND ITEMS: # 23 PART I, 27 PER MEO 7/7/99 11-18-99 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Certificate of Death

Reg. No.

99 36101

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Robert Edward Tuitt | | 2. Date of Death Month Day Year November 09, 1999 | | 3. Time of Death 2:14 P.M. | |
| 4a. Facility Name (If not institution, give street and number) Mercy Hospital | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A |
| 5. Social Security Number 121-58-3947 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 33 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) February 12, 1966 |
| 9. Birthplace (State or Foreign Country) Brooklyn, NY | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State NY | 10b. County Kings | 10c. City, Town or Location Brooklyn | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 105 Ashland Place, Apt-6D | | | 10f. Zip Code 11201 | | 10g. Citizen of What Country? United States |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White BLACK | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled | | 16b. Kind of Business/Industry N/A | |
| 17. Father's Name (First, Middle, Last) Hezekiah Tuitt | | | 18. Mother's Name (First, Middle, Maiden Surname) Ruth Thompson | | |
| 19a. Informant's Name/Relationship (Type, Print) Ruth Tuitt / Mother | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Ashland Place, Apt-6D Brooklyn NY 11201 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Religious Society of Friends Nov. 18, 1999 Brooklyn, NY | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. | | 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIOMEGALY | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): | | | | | |
| b. Due to (or as a consequence of): | | | | | |
| c. Due to (or as a consequence of): | | | | | |
| d. Due to (or as a consequence of): | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier Dr. [Signature] | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) November 10, 1999 | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) H. [Signature] 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature [Signature] | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36102

| | | | | | | | | | | | | | | | |
|--|---|---|---|---|--|--|---|--|---|---|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARGARET CLAUDIA TAYLOR | | | | | | 2. Date of Death Month Day Year NOVEMBER 14 1999 | | 3. Time of Death 6:50am | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 3125 ABEL AVE. | | | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | | | | | |
| Funeral Director | 5. Social Security Number 220-68-3182 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 44 Yrs. | | 8. Date of Birth (Month, Day, Year) 04/30/1955 | | 9. Birthplace (State or Foreign Country) MARYLAND | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 10e. Street and Number 3125 ABEL AVE. | | | | 10f. Zip Code 21218 | | | | 10g. Citizen of What Country? USA | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SOCIAL WORKER | | | | 16b. Kind of Business/Industry SOCIAL WORK | | | | | | | |
| 17. Father's Name (First, Middle, Last) GEORGE MEEHAN | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARGARET J. TAYLOR | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) RICHARD D. ADAMS (COUSIN) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 OLD PASTURE LANE. SEVERNA PARK, MD 21146 | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) PARKWOOD | | Date 11/16/99 | | 20c. Location - City or Town, State BALTO., MD. | | | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | | | 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212. | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. <u>Respiratory failure</u> Due to (or as a consequence of):</td> <td rowspan="4"> Approximate Interval Between Onset and Death <u><48 hrs.</u> <u>6 months</u> </td> </tr> <tr> <td>b. <u>Ovarian cancer - metastatic progressive disease</u> Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>Respiratory failure</u> Due to (or as a consequence of): | Approximate Interval Between Onset and Death <u><48 hrs.</u> <u>6 months</u> | b. <u>Ovarian cancer - metastatic progressive disease</u> Due to (or as a consequence of): | c. _____ Due to (or as a consequence of): | d. _____ Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>Respiratory failure</u> Due to (or as a consequence of): | Approximate Interval Between Onset and Death <u><48 hrs.</u> <u>6 months</u> | | | | | | | | | | | | | |
| | b. <u>Ovarian cancer - metastatic progressive disease</u> Due to (or as a consequence of): | | | | | | | | | | | | | | |
| | c. _____ Due to (or as a consequence of): | | | | | | | | | | | | | | |
| | d. _____ Due to (or as a consequence of): | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | | | | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | | | 29c. License number DS1017 | | 29d. Date signed (Month, Day, Year) NOVEMBER 15, 1999 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANDRA E. BROOKS, M.D., 405 WEST REDWOOD STREET, BALTIMORE, MD., 21201 | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | | | 32. Registrar's Signature  | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36103

Pt. Known as Gersh Vayner.
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Funeral
Director

Physician
/Medical
Examiner

| | | | | | |
|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) GERSH VAYNER | | 2. Date of Death Month Day Year November 12, 1999 | | 3. Time of Death 11:45 AM | |
| 4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| 5. Social Security Number 219-35-5801 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 95 Yrs. | |
| 8. Date of Birth (Month, Day, Year) 10-13-1904 | | 9. Birthplace (State or Foreign Country) BRICHAN, MOLDOVA | | | |
| 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 2434 WEST BELVEDERE AVENUE | | 10f. Zip Code 21215 | |
| 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS College (1-4or 5+) | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BAKER | | 16b. Kind of Business/Industry BAKERY | | 17. Father's Name (First, Middle, Last) MOSHA VAYNER | |
| 18. Mother's Name (First, Middle, Maiden Surname) HANNAH FLEXER | | 19a. Informant's Name/Relationship (Type, Print) MR. GLEN SIDILNIKOV -GRANDSON | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 439 DOE MEADOW DRIVE OWINGS MILLS, MD 21117 | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW CONG.- | | 20c. Location - City or Town, State 11/14/1999 BALTIMORE, MARYLAND | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility SOL LEVINSON BROS., INC. 8900 REISTERSTOWN ROAD 21208 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Renal Failure Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier MD | | 29c. License number RES 0000 | |
| 29d. Date signed (Month, Day, Year) 11/12/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Nelson 2401 W. Belvedere Ave. Baltimore, MD 21205 | | 31. Date filed (Month, Day, Year) NOV 17 1999 | |
| 32. Registrar's Signature | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36104

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GLADYS

VANLANDINGHAM

2. Date of Death

Month

Day

Year

NOVEMBER 13 1999

3. Time of Death

3:12PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

217-26-4286

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

APRIL 10, 1916

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3808 SEQUOIA AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

CHARLES

HARRELL

18. Mother's Name (First, Middle, Maiden Surname)

SALLY

WHITEHURST

19a. Informant's Name/Relationship (Type, Print)

MIKE GARRISON (GRANDSON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3411 WASHINGTON AVENUE, BALTIMORE, MD. 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST CEME. 11-19-99 OWINGS MILLS, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME

2140 N. FULTON AVE, BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

b. CHRONIC RENAL FAILURE

Due to (or as a consequence of):

c. DIABETES MELLITUS

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

NOVEMBER 13 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edwin Davis

Sinai

Hospital

Baltimore

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NOT A COPY OF THE ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36105

| | | | | | | | | |
|---|---|---|--|--|--|--|----------------------------------|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Yvonne J. Wade</i> | | | | 2. Date of Death Month <i>11</i> - Day <i>13</i> - Year <i>99</i> | | 3. Time of Death <i>0415</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>Deaton University of Maryland Medicine Baltimore</i> | | | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | 4c. County of Death <i>NA</i> | |
| Funeral Director | 5. Social Security Number <i>212-44-2085</i> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>55</i> Yrs. | 8. Date of Birth (Month, Day, Year) <i>7/11/44</i> | 9. Birthplace (State or Foreign Country) <i>MD</i> | | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State <i>MD</i> | | 10b. County <i>NA</i> | | 10c. City, Town or Location <i>BALTIMORE</i> | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number <i>1535 MT. MORE CT.</i> | | | | 10f. Zip Code <i>21217</i> | | 10g. Citizen of What Country? <i>USA</i> | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>African American</i> | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>NEVER WORKED</i> | | 16b. Kind of Business/Industry <i>NA</i> | | |
| 17. Father's Name (First, Middle, Last) <i>Melvin Wade</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Virginia Powell</i> | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Bridgette Tyree daughter</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>45 S. Fulton Ave. Baltimore, MD</i> | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt. Zion Cemetery</i> | | Date <i>11/19/99</i> | | 20c. Location - City or Town, State <i>Lansdowne, MD</i> | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility <i>Albert P. Wade Funeral Am PA 658 N. Belmor St. Baltimore, MD 21217</i> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Intracranial Bleeding</i> Due to (or as a consequence of): <i>hypertension</i> Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>seizures</i> Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death <i>1 month</i> <i>15-3</i> <i>1 month</i> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number <i>D 3041941</i> | | 29d. Date signed (Month, Day, Year) <i>11/13/99</i> | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>DEAL K. Deaton medical center 611 south charles st Baltimore MD 21201</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>NOV 17 1999</i> | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36106

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John J. Will, Jr.

2. Date of Death
Month Day Year
November 13, 19993. Time of Death
2:37 PM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

ROSCDALE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

215-12-7973

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

November 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2709 Fifth Avenue

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

owner

16b. Kind of Business/Industry

Will's Dairy

17. Father's Name (First, Middle, Last)

John J. Will, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Bremiller

19a. Informant's Name/Relationship (Type, Print)

Mrs. John Will, Jr. - Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2709 Fifth Avenue Parkville, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Oaklawn

Date

Nov. 17,
1999

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Heather Cain

22. Name and Address of Facility

Evans Chapel of Memories
8800 Harford Road
Baltimore, Maryland 2123423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Atherosclerotic Coronary Vascular disease

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician:To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Bradford L. Elright MD

29c. License number

045568

29d. Date signed (Month, Day, Year)

11/16/99

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

BRADFORD L. EBRIGHT

9524

Belair Rd

Balt, MD

21236

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WILL, JOHN JULIUS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36107

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

| | | | | | |
|---|--|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last) Delores Jean Wilson | | 2. Date of Death Month Day Year NOVEMBER 13 1999 | | 3. Time of Death 3:10 A | |
| 4a. Facility Name (If not institution, give street and number) BON SECOURS HOSPITAL | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death n/a |
| 5. Social Security Number 219-26-8849 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 60 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Dec. 26, 1938 |
| Usual Residence of Decedent | | | 9. Birthplace (State or Foreign Country) NC | | |
| 10a. State Md. | 10b. County n/a | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 3307 Fairview Avenue | | | 10f. Zip Code 21216 | | 10g. Citizen of What Country? USA |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Private Duty Nurse | | 16b. Kind of Business/Industry Private Families | | | |
| 17. Father's Name (First, Middle, Last) Jasper Evans | | | 18. Mother's Name (First, Middle, Maiden Surname) Stella Carter | | |
| 19a. Informant's Name/Relationship (Type, Print) Antonica Ingram Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6205 Park Heights Avenue Baltimore, Md. 21215 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park | | 20c. Location - City or Town, State Nov. 16 Baltimore, Md. | |
| 21. Signature of Funeral Service Licensee Ernest R. Ferry Jr. | | 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hypertensive Arteriosclerotic Cardiovascular Disease | | | | | |
| Due to (or as a consequence of): | | | | | |
| Due to (or as a consequence of): | | | | | |
| Due to (or as a consequence of): | | | | | |
| Due to (or as a consequence of): | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? INSPECTION | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier Dennis J. Chute | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) NOVEMBER 13, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature B. Sparks | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36108

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Betty

J

Williams

2. Date of Death

November 13 1999

Day

Year

3. Time of Death

19:11

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

214-56-3963

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

JULY 14, 1952

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

940 N. PATTERSON PARK AVE.

10f. Zip Code

21205

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

AFRO-AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11TH

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEKEEPER

16b. Kind of Business/Industry

HOTEL BUSINESS

17. Father's Name (First, Middle, Last)

JAMES HENRY WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET REED

19a. Informant's Name/Relationship (Type, Print)

TYRA L. FOSTER / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1001 N. GAY ST. APT 104 BALTO, MD. 21205

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CEMETERY

Date

NOV. 19, 1999 BALTO, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Calvin B. Scruggs

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON STREET BALTO, MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. pneumococcal pneumonia

Due to (or as a consequence of):

24 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. human immunodeficiency virus infection

Due to (or as a consequence of):

12 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hepatitis B virus

hepatitis C virus

alcohol abuse

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Aimee K. Zaas, MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

November 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns Hopkins Hospital Tower 110 Baltimore, MD 21287

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

*B. Sparks*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#28a perPhyG777 11/19/99 EW

Certificate of Death

Reg. No.

99 36109

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

David Walters

2. Date of Death

November 12

Day

1999

Year

3. Time of Death

1615 PM

4a. Facility Name (If not institution, give street and number)

DEATON Specialty Hosp & Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

214-38-0311

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

April 21, 1934

9. Birthplace (State or Foreign Country)

Missouri

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3843 Falls Road 2 South

10f. Zip Code

21211

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manual Labor

16b. Kind of Business/Industry

Baltimore Packaging

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Summa)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Helen Martin/ Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3843 Falls Road 2 South Baltimore, MD 21211

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory, Inc.

Date

11/14/99

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Laura C. Hardesty

22. Name and Address of Facility

CAFA Stephen D. Lohmann, PA
8717 Green Pastures Drive Baltimore, Maryland 21286

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Aspiration pneumonia

Approximate Interval Between Onset and Death

2 days

Due to (or as a consequence of):

b. quadriparesis because of motor vehicle accident

2 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending investigation2 ☒ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

10-28-99

28b. Time of Injury

1845 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

pedestrian struck by minivan

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3200 Park Fleet Street Baltimore, MD

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 30494

29d. Date signed (Month, Day, Year)

November 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. Desai MD, Medical Center, 11500 Chesapeake St Baltimore MD 21230

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Dr. Desai

CERTIFICATION APPROVED MEDICAL EXAMINER

WALTERS, DAVID

AH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 5 per fh 3/10/00 yg G781

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36110

| | | | | | | | | |
|--|--|--|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Jacqueline E. Yellowdy | | | | 2. Date of Death Month Day Year November 8, 1999 | | 3. Time of Death 12:20pm | |
| | 4a. Facility Name (If not institution, give street and number) 804 Radnor Avenue | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 212-28-8411 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 67 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Dec. 31, 1931 | | 9. Birthplace (State or Foreign Country) MD. |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md. | 10b. County N/A | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 804 Radnor Avenue | | | 10f. Zip Code 21212 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Claims Adjuster | | 16b. Kind of Business/Industry Dept. of Health & Welfare Social Security | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Yo Orlando Jones | | | | 18. Mother's Name (First, Middle, Maiden Surname) Thelma Hawkins | | | |
| | 19a. Informant's Name/Relationship (Type, Print) sister Yolanda Proctor | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4807 The Alameda Baltimore, MD. 21239 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial Park | | 20c. Location - City or Town, State Nov. 12 Baltimore, Md. | | | |
| | 21. Signature of Funeral Service Licensee Herbert E. Nutter | | 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynn's Falls Pkwy Baltimore, Md. 21216 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Ovarian Carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death 1 year | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Dan M. Hel | | 29c. License number 020398 | | 29d. Date signed (Month, Day, Year) November 10, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Davis M. Hahn 5801 Loch Raven Blvd Balto Md 21239 | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 17 1999 | | 32. Registrar's Signature Davis M. Hahn | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36111

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James Linden Archibald, Sr. | | | | 2. Date of Death Month November Day 4 Year 1999 | | 3. Time of Death 1120 | |
| | 4e. Facility Name (If not institution, give street and number) Union Hospital of Cecil County | | | | 4b. City, Town, or Location of Death Elkton | | 4c. County of Death Cecil | |
| Funeral Director | 5. Social Security Number 217-20-0757 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | 8. Date of Birth (Month, Day, Year) October 4, 1927 | |
| | 10a. State Maryland | | 10b. County Cecil | | 10c. City, Town or Location Elkton | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number 139 West High Street | | | | 10f. Zip Code 21921 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WWII If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) 3 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chief Weapons Facilities Division | | 16b. Kind of Business/Industry U.S. Government | |
| | 17. Father's Name (First, Middle, Last) James L. Archibald | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sadie Knight | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Dorothy M. Archibald/ wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 139 West High Street, Elkton, Maryland 21921 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Immaculate Conception Cemetery | | Date 11/8/99 | | 20c. Location - City or Town, State Cherry Hill, Maryland | |
| | 21. Signature of Funeral Service Licensee Daniel S. Hicks | | | | 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Physician /Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier Jayantilal K Patel MD | | | | 29c. License number A22307 | | 29d. Date signed (Month, Day, Year) NOV 4 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAYANTILAL K PATEL MD 123 SINGERLY AVE, ELKTON, MD 21921 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 05 1999 | | | | 32. Registrar's Signature Brenda B. Sparks | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36112

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Henry J. Burgett

2. Date of Death
Month Day Year

November 4 1999

3. Time of Death

9:55AM

4a. Facility Name (If not institution, give street and number)

VA Maryland Health Care System

4b. City, Town, or Location of Death

Perry Point

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

215-58-0638

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

June 11, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Perry Point

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

VA Medical Center

10f. Zip Code

21902

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1928-
193013. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
6

College (1-4or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Never worked

16b. Kind of Business/Industry

Never worked

17. Father's Name (First, Middle, Last)

Henry Burgett

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Helen Guidice/ Social Worker

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

VA Medical Center, Perry Point, Maryland 21902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Maryland Veterans Cemetery

Date

November
10, 1999

20c. Location - City or Town, State

Garrison Forest,
Maryland

21. Signature of Funeral Service Licentiate

22. Name and Address of Facility

Crouch Funeral Home

127 South Main Street, North East, Maryland 21901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Schizophrenia

Multi Infarct Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
injury28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Melecia Santos, M.D.

29c. License number

151094-1

29d. Date signed (Month, Day, Year)

11-4-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Melecia Santos, M.D. VA Maryland Health Care System Perry Point, MD 21902

31. Date filed (Month, Day, Year)

NOV 08 1999

32. Registrar's Signature

Benjamin S. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME KNOWN TO PHYSICIAN: Burgett, Henry J
Baltimore, Maryland 21215-0020Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-354-3000.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.

5 + IVA

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

99 36113

| | | | | | | | | |
|--|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Gilbert Angelo Bruno | | | | 2. Date of Death Month Day Year November 5, 1999 | | 3. Time of Death 10:55 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) 52 Cherokee Drive | | | | 4b. City, Town, or Location of Death North East | | 4c. County of Death Cecil | |
| Funeral Director | 5. Social Security Number 010-14-4923 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 86 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) November 11, 1912 | |
| | 9. Birthplace (State or Foreign Country) Massachusetts | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State Maryland | | 10b. County Cecil | | 10c. City, Town or Location North East | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 10e. Street and Number 52 Cherokee Drive | | | | 10f. Zip Code 21901 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1946 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Engineer | | | 16b. Kind of Business/Industry Road Construction | |
| 17. Father's Name (First, Middle, Last) Alphonso Bruno | | | | 18. Mother's Name (First, Middle, Maiden Surname) Vaine Casassa | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Richard Bruno / Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 52 Cherokee Drive, North East, Maryland 21901 | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris Co., Inc. | | Date November 6, 1999 | | 20c. Location - City or Town, State West Chester, Pennsylvania | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <u>Respiratory Arrest</u> Due to (or as a consequence of): b. <u>Small Cell Lung Cancer</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | | | Approximate Interval Between Onset and Death 2 months |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number H0035860 | | 29d. Date signed (Month, Day, Year) 11/6/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Irving M. Berkowitz, Christiana Hospital, | | | | 4755 Ogletown Stanton Road, Stanton, Delaware | | | | |
| 31. Date filed (Month, Day, Year) NOV 08 1999 | | | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

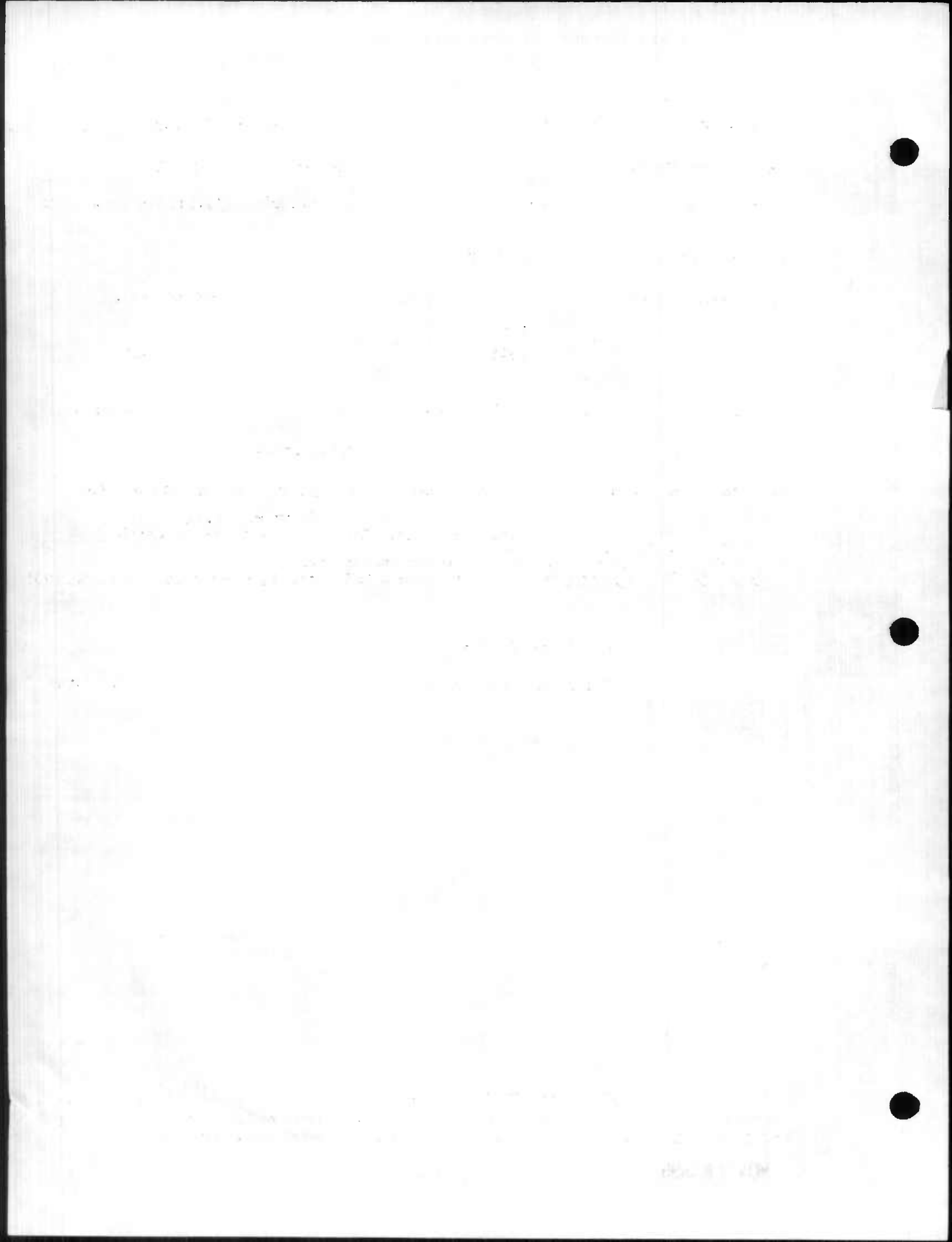
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36114

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ISOBELLA EDITH BURNS

2. Date of Death

November 06 1999

3. Time of Death

7:50 A.M.

4a. Facility Name (If not institution, give street and number)

MALCOLM GROW MEDICAL CENTER

4b. City, Town, or Location of Death

CAMP SPRINGS

4c. County of Death

PRINCE GEORGE'S

Funeral
Director

5. Social Security Number

229-36-0328

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Nov. 27, 1919

9. Birthplace (State or Foreign Country)

Canada

Usual Residence of Decedent

10e. State
Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10605 Mahogany Court

10f. Zip Code

20601

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Legal Secretary

16b. Kind of Business/Industry

Private Law Office

17. Father's Name (First, Middle, Last)

James Carr

18. Mother's Name (First, Middle, Maiden Surname)

Edith Emily Harris

19a. Informant's Name/Relationship (Type, Print)

Loran C. Burns/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10605 Mahogany Court, Waldorf, Maryland 20601

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Huntt Crematory

Date

11-7-1999

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

JOHN P. KNISLEY

22. Name and Address of Facility

The Huntt Funeral Home, Inc.
P.O. Box 156, Waldorf, Maryland 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. METASTATIC PANCREATIC CANCER

Due to (or as a consequence of):

b. PROTEIN CALORIE MALNUTRITION

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of certifier

Thomas G. Fraser

29c. License number

OHIO 35-07-0341-F

29d. Date signed (Month, Day, Year)

NOVEMBER 06 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS G FRASER, CAPT, USAF, MD

ANDREWS AIR FORCE BASE, MD 20762-6600

State
Registrar

31. Date filed (Month, Day, Year)

NOV 09 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36115

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--------------------------------|---|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Alice Brown | | | | | | 2. Date of Death Month: November Day: 2 Year: 1999 | | 3. Time of Death 8:25PM | |
| | 4e. Facility Name (If not institution, give street and number) 106 Colton St. | | | | | | 4b. City, Town, or Location of Death Upper Marlboro | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 579-52-1875 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 60 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 13, 1938 | | 9. Birthplace (State or Foreign Country) Wash., D.C. | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Upper Marlboro | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number 106 Colton Street | | | | 10f. Zip Code 20774 | | | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) 12th | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | | | 16b. Kind of Business/Industry Private | | |
| 17. Father's Name (First, Middle, Last) John Savoy, Sr. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ada Tyler | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Vicki H. Gordon - Daughter | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10612 Broadleaf Dr., Upper Marlboro, MD 20774 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park | | 20c. Date 11/9/99 | | 20d. Location - City or Town, State Landover, MD | | |
| 21. Signature of Funeral Service Licensee John T. Stewart, III | | | | | | 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 | | | | |
| 23a. Part I. Enter the disease, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC lung CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sarcoidosis Chronic Obstructive lung Disease Diabetes Mellitus | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| 29b. Signature and title of certifier William DuBois, MD | | | | 29c. License number 047603 | | | | 29d. Date signed (Month, Day, Year) 11/03/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William DuBois, MD 79 Kettering Dr. Upper Marlboro, MD 20774 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 05 1999 | | | | 32. Registrar's Signature [Signature] | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36116

Certificate of Death

Amend # 12 Per FAM. PGC 11-5-99 cr

Reg. No.

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|--|--|--|--|--|---|----------------------------------|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James Franklin Berry | | | | 2. Date of Death Month Day Year November 4, 1999 | | 3. Time of Death 1:00 P.M. | | | | | | | | | | | |
| | 4e. Facility Name (If not institution, give street and number) Livingston Health Care Center | | | | 4b. City, Town, or Location of Death Ft. Washington | | 4c. County of Death Prince Georges | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 578-32-7273 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 71 Yrs. | | 8. Date of Birth (Month, Day, Year) November 15, 1927 | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Prince Georges | | 10c. City, Town or Location Fort Washington | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | | | | |
| 10a. State Maryland | | | 10b. County Prince Georges | | | 10c. City, Town or Location Fort Washington | | | | | | | | | | | | |
| 10e. Street and Number 11410 Fort Washington Road | | | 10f. Zip Code 20744 | | | 10g. Citizen of What Country? U.S.A. | | | | | | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1946-1947 | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | | | | | | | | | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervising Operating Engineer | | | | | | | | | | | | |
| 16b. Kind of Business/Industry D.C. Government | | | 17. Father's Name (First, Middle, Last) Samuel S. Berry | | | 18. Mother's Name (First, Middle, Maiden Surname) Goldie Raum | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) June Tilch Berry/Wife | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11410 Ft. Washington Rd., Ft. Washington, MD 20744 | | | | | | | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery | | | 20c. Location - City or Town, State 11/10/99 Cheltenham, MD | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee George P. Kalas | | | 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. <u>Aspiration Pneumonitis</u></td> <td rowspan="4"> Due to (or as a consequence of): b. <u>END STAGE PARKINSON'S DISEASE</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ </td> <td rowspan="4"> Approximate Interval Between Onset and Death <u>2 wks</u> <u>4 yrs</u> </td> </tr> <tr><td colspan="2"></td></tr> <tr><td colspan="2"></td></tr> <tr><td colspan="2"></td></tr> </table> | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>Aspiration Pneumonitis</u> | Due to (or as a consequence of): b. <u>END STAGE PARKINSON'S DISEASE</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | Approximate Interval Between Onset and Death <u>2 wks</u> <u>4 yrs</u> | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>Aspiration Pneumonitis</u> | Due to (or as a consequence of): b. <u>END STAGE PARKINSON'S DISEASE</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | Approximate Interval Between Onset and Death <u>2 wks</u> <u>4 yrs</u> | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28d. Describe how injury occurred | | | | | | | | | | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier M. Nedzbal | | | 29c. License number DC007348 | | | 29d. Date signed (Month, Day, Year) Nov. 4, 1999 | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert M. Nedzbal, M.D. 11701 Livingston Rd. #101, Ft. Washington, MD 20744 | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 05 1999 | | | 32. Registrar's Signature A. [Signature] | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

11/11

IN Kasse

M.D. 11701 11/11/11

NOV 2 1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36117

| | | | | | | | | |
|---|---|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Earl Junior Caynor | | | | 2. Date of Death Month November Day 4 Year 1999 | | 3. Time of Death 1958 | |
| | 4e. Facility Name (If not institution, give street and number) Union Hospital of Cecil County | | | | 4b. City, Town, or Location of Death Elkton | | 4c. County of Death Cecil | |
| Funeral Director | 5. Social Security Number 235-22-2096 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) October 27, 1922 | |
| | 9. Birthplace (State or Foreign Country) West Virginia | | 10a. State Maryland | | 10b. County Cecil | | 10c. City, Town or Location North East | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 36 Timberlane Drive | | 10f. Zip Code 21901 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Heavy Equipment Operator | | 16b. Kind of Business/Industry Road Construction | | | |
| | 17. Father's Name (First, Middle, Last) Earl Caynor | | 18. Mother's Name (First, Middle, Maiden Surname) Grace Keener | | 19a. Informant's Name/Relationship (Type, Print) Ernetta May Keyes / Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36 Timberlane Drive, North East, Maryland 21901 | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Georges Cemetery | | 20c. Location - City or Town, State St. Georges, Delaware | | 20d. Date November 9, 1999 | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCVD Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last ASCVD Due to (or as a consequence of): Approximate Interval Between Onset and Death years | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number 00051035 | | 29d. Date signed (Month, Day, Year) November 4, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Stephanie Ortega MD Union Hospital 100 Bow St Elkton, MD 21921 | | 31. Date filed (Month, Day, Year) NOV 08 1999 | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36118

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM COOPER

2. Date of Death
Month Day Year
NOVEMBER 3 1999

3. Time of Death
6-10 PM

4a. Facility Name (If not institution, give street and number)

Bayside Care Center

4b. City, Town, or Location of Death

Lexington Park

4c. County of Death

St. Mary's

Funeral
Director

5. Social Security Number

24-13-2471

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 16, 1908

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Lexington Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

21412 Great Mills Road

10f. Zip Code

20653

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
6th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farming

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

James Lucas - Son-in-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

37099 Asher Road, Mechanicsville, MD 20659

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

11/9/99

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee

John T. Stewart II

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertension

Due to (or as a consequence of):

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Renal Failure

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

4 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

SC Gaby

29c. License number

D54346

29d. Date signed (Month, Day, Year)

11/3/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHANDRA B. SAJJIA, M.D.

PHILIP J. BEAN MEDICAL CENTER, 24035, THREE NOTCH RD, HOLLYWOOD, MD 20636

31. Date filed (Month, Day, Year)

NOV 05 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36119

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Rose Marie Cephas

2. Date of Death
Month Day Year

October 30, 1999

3. Time of Death

0855

4a. Facility Name (If not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

213-42-0480

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 04, 1943

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Vienna

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4478 Fork Neck Road

10f. Zip Code

21869

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Counselor

16b. Kind of Business/Industry

Rehabilitation Center

17. Father's Name (First, Middle, Last)

Peter James McCreedy

18. Mother's Name (First, Middle, Maiden Surname)

Alice Johnson

19a. Informant's Name/Relationship (Type, Print)

Kevin Cephas

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

803 Center Street Cambridge, Maryland 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fork Neck Cemetery

Date

11/05/99

20c. Location - City or Town, State

Vienna, Maryland

21. Signature of Funeral Service Licensee

Janelle C. Henry

22. Name and Address of Facility

Henry Funeral Home P.A.

510 Washington St. Cambridge, Maryland 21613

23a. Part 1. Enter the disease, or complications that caused the death, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

b. Dilated Cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

60 minutes

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Type One Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☒ Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Eugene J. Newmiller MD-Physician

29c. License number

H51793

29d. Date signed (Month, Day, Year)

10/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugene Newmiller D.O. 503 Byrn St. Cambridge MD 21613

31. Date filed (Month, Day, Year)

NOV 02 1999

32. Registrar's Signature

B. Spaw

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36120

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

REGINA LUCY DESMARAIS

2. Date of Death

November 3, 1999

3. Time of Death

2:15PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

5004 Rayburn Court

4b. City, Town, or Location of Death

Camp Springs

4c. County of Death

Prince George's

5. Social Security Number

024-22-0961

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

November 9, 1929

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Camp Springs

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5004 Rayburn Court

10f. Zip Code

20748

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

At Home

17. Father's Name (First, Middle, Last)

Luigi Perrotti

18. Mother's Name (First, Middle, Maiden Surname)

Concetta Andreano

19a. Informant's Name/Relationship (Type, Print)

Armand J. Desmarais/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as item 10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cemetery 11/10/99 Arlington, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

George P. Kalas

22. Name and Address of Facility

George P. Kalas Funeral Home, P.A.

6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. cardiopulmonary arrest

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. recurrent ovarian carcinoma

Due to (or as a consequence of):

c. chronic obstructive pulmonary disease

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mary F. Parker, MD

29c. License number

D40248

29d. Date signed (Month, Day, Year)

Nov. 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary Parker, M.D. Walter Reed Army Medical Center 6825 16th St. N.W. Wash. DC 20307

31. Date filed (Month, Day, Year)

NOV 05 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

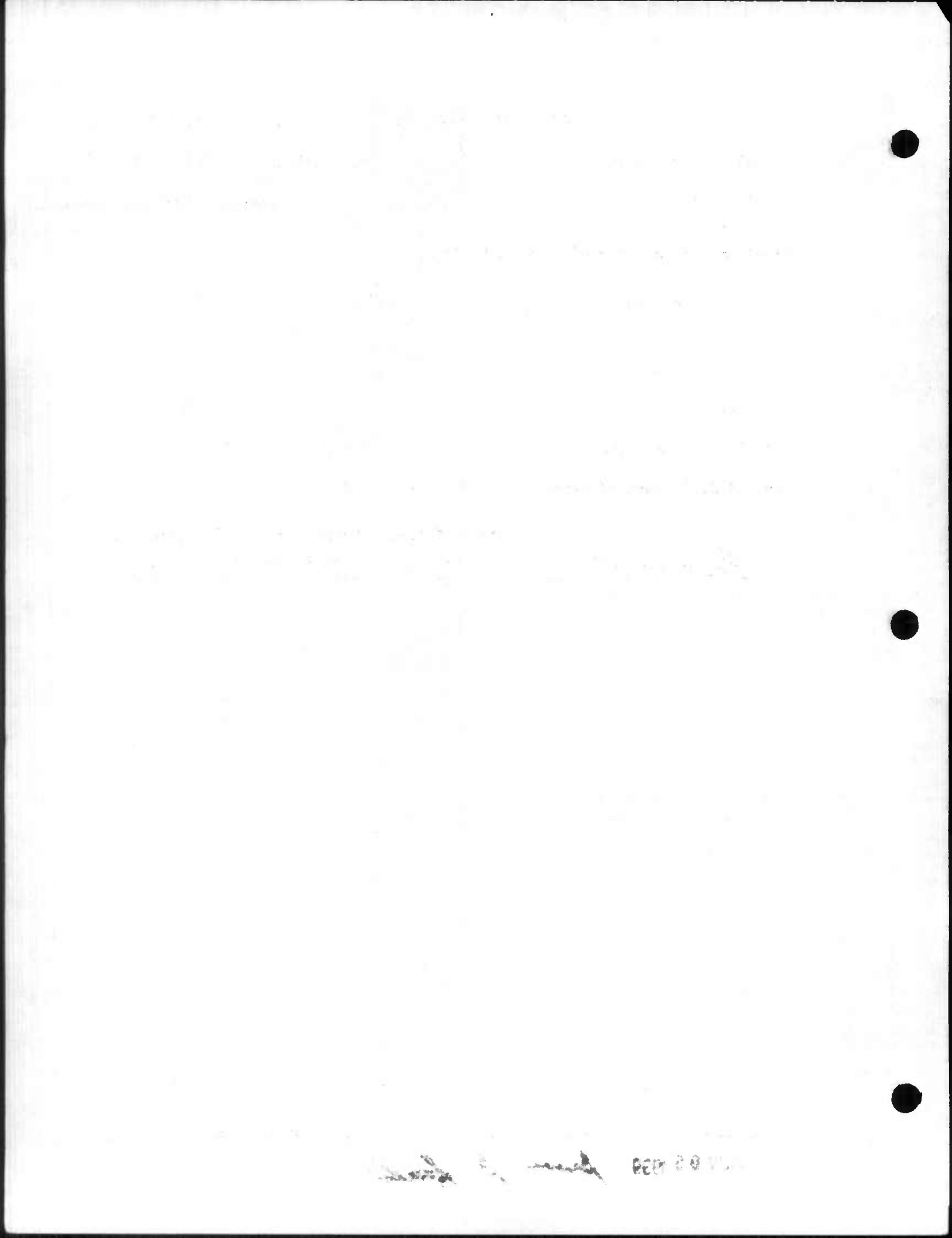
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36121

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Eleanor M. Durbin

2. Date of Death

November 2 1999

Day

Year

3. Time of Death

1:15 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

185-05-5701

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Feb. 17, 1918

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

College Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5705 Berwyn Road

10f. Zip Code

20740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William I. Miller

18. Mother's Name (First, Middle, Maiden Surname)

Wilhelmina Roessing

19a. Informant's Name/Relationship (Type, Print)

Charles G. Durbin, Jr. - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4522 Catterton Road, Free Union, Virginia 22940

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Baltimore National Cemetery

Date

11/08/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Ceri Lynn Masch-Hardy

22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Acute Arrhythmia
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Coronary Artery Disease
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D27824

29d. Date signed (Month, Day, Year)

11/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ELIZABETH KIMMETT, 1351 GREENBRIAR RD, YORK, PA 12404

31. Date filed (Month, Day, Year)

NOV 05 1999

32. Registrar's Signature

[Signature]

State
Registrar

MON 20 1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36122

| | | | | | | | | |
|--|---|---|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Leota Margaret Denevan | | | | | 2. Date of Death Month Day Year November 2, 1999 | | 3. Time of Death 13:40 |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel |
| Funeral Director | 5. Social Security Number 218-20-1485 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 86 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Dec. 7, 1912 | | 9. Birthplace (State or Foreign Country) South Dakota |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location College Park | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 8704 49th Avenue | | | 10f. Zip Code 20740 | | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse | | | 16b. Kind of Business/Industry Prince George's Hospital Center | | |
| 17. Father's Name (First, Middle, Last) Louis Byron Askew | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Toussaint | | | |
| 19a. Informant's Name/Relationship (Type, Print) Francis J. Denevan - Son | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8706 49th Avenue, College Park, Maryland 20740 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery | | Date 11/05/99 | 20c. Location - City or Town, State Clinton, Maryland | | |
| 21. Signature of Funeral Service Licensee Cen Lynn Gasch-Grady | | | | | 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 | | | |
| 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Arrest Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): c. Upper GI Bleeding Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 1 wh 1 wh |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Robert C. Moore | | | | 29c. License number MD 25178 | | 29d. Date signed (Month, Day, Year) 11/3/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT C. MOORE Anne Arundel Annapolis MD 21401 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 05 1999 | | 32. Registrar's Signature Shane S. [Signature] | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36123

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LILLIAN B. EVANS | | | | 2. Date of Death Month Day Year November 3, 1999 | | 3. Time of Death 6:00 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) Collington Episcopal Life Care Center | | | | 4b. City, Town, or Location of Death Mitchellville | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 144-22-8629 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) July 30, 1913 | |
| | 9. Birthplace (State or Foreign Country) Virginia | | 10e. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Mitchellville | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10f. Zip Code 20721 | | 10g. Citizen of What Country? United States | | 10h. Street and Number 10450 Lottsford Road | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher | | 16b. Kind of Business/Industry Government | | 17. Father's Name (First, Middle, Last) Thomas Ball | | |
| 18. Mother's Name (First, Middle, Maiden Surname) LaVerta Norman | | 19a. Informant's Name/Relationship (Type, Print) Junius Jeffries - Brother-in-Law | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10450 Lottsford Rd., Mitchellville, MD 20721 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Beulah Baptist Church | | 20c. Location - City or Town, State Minor, VA | | 21. Signature of Funeral Service Licensee John T. Stewart, III | | 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple Myeloma Anemia Parkinson's Disease | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier William DuBois, MD | | |
| 29c. License number 047603 | | 29d. Date signed (Month, Day, Year) 11/04/99 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) William DuBois, MD 79 KETTERING Dr. Upper Marlboro, MD 20774 | | 31. Date filed (Month, Day, Year) NOV 05 1999 | | |
| 32. Registrar's Signature James B. Smith | | | | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1944-1945

1944-1945

1944-1945

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36124

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Martha Jane Foreaker | | | | | 2. Date of Death Month Day Year November 4, 1999 | | 3. Time of Death 14:45 |
| | 4a. Facility Name (If not institution, give street and number) Laurelwood Care Center | | | | | 4b. City, Town, or Location of Death Elkton | | 4c. County of Death Cecil |
| Funeral Director | 5. Social Security Number 215-32-0508 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 93 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 30, 1906 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Cecil | | 10c. City, Town or Location North East | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 185 Old Log Cabin Road | | | | 10f. Zip Code 21901 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry In her own home | |
| 17. Father's Name (First, Middle, Last) Harry Reynolds | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Florence Hill | | | |
| 19a. Informant's Name/Relationship (Type, Print) John Foreaker / Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 185 Old Log Cabin Road, North East, Maryland 21901 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) North East Methodist Cemetery | | | 20c. Location - City or Town, State North East, Maryland | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Coronary Artery Disease</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier | | | 29c. License number D0032395 | | 29d. Date signed (Month, Day, Year) November 5, 1999 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Mauldin Avenue, North East, Maryland 21901 Thomas E. Finucan MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 05 1999 | | | 32. Registrar's Signature Benjamin B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

DHMH 16 Rev 6/95

ORIGINAL

99-6583-033

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

JOHN

State of Maryland / Department of Health and Mental Hygiene

FORD AMEND ITEMS: #23 PART I, 27, 28A- PER MEO G77 11-18-99 WR. 99 36125

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John Wilber Ford, Jr. | | | | 2. Date of Death Month Day Year NOVEMBER 3, 1999 | | 3. Time of Death 12:38P.M. | |
| | 4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL | | | | 4b. City, Town, or Location of Death CHEVERLY | | 4c. County of Death PRINCE GEORGES | |
| Funeral Director | 5. Social Security Number 213-42-9564 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 55 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 27, 1944 | |
| | 9. Birthplace (State or Foreign Country) Washington, D.C. | | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location District Heights | |
| Usual Residence of Decedent | | 10e. Street and Number 1914 Rochelle Ave. | | 10f. Zip Code 20747 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Worker | | 16b. Kind of Business/Industry Government | | | | |
| 17. Father's Name (First, Middle, Last) John Wilber Ford, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Theresa Brown | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Dorothy Ford/ Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6017 Seat Pleasant Dr. Capitol Heights, Md. 20748 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park | | Date 11/9/99 | | 20c. Location - City or Town, State Landover, Md. | | |
| 21. Signature of Funeral Service Licensee <i>Keith A. King</i> 11/085 | | | | 22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747 | | | | |
| 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | CHEST INJURIES COMPLICATING HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) 11-3-99 | | 28b. Time of Injury 11:53 M | | 28c. Injury at Work? XX Yes 2 <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred SUBJECT DRIVER OF TRUCK STRUCK LIGHT POLE | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) PARKING LOT | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10251 OLD LARGO RD. LARGO, MD. | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Theodore M. King</i> | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) NOVEMBER 4, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>THEODORE M. KING</i> | | 111 Penn Street, Baltimore, Maryland 21201 | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 10 1999 | | 32. Registrar's Signature <i>James A. Sparks</i> | | | | | | |

ORIGINAL

NOV 10 1955

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36127

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

JOSEPH RICHARD GOOSEBERRY, JR.

2. Date of Death
Month Day Year
November 4, 19993. Time of Death
3:30PM

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

5. Social Security Number

218-30-3798

6. Sex
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67

If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)

OCT. 4, 1932

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

ROCKPOINT

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13597 FURBUSH ROAD

10f. Zip Code

20682

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
7th

College (1-4or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

OYSTERMAN

16b. Kind of Business/Industry

OYSTERING

17. Father's Name (First, Middle, Last)

JOSEPH RICHARD GOOSEBERRY, SR.

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET ELIZABETH MIDDLETON

19a. Informant's Name/Relationship (Type, Print)

JAMES PAUL GOOSEBERRY / BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13597 FURBUSH ROAD ROCKPOINT, MD 20682

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

HOLY GHOST CHURCH CEMETERY 11/9/99 ISSUE, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

LYDIA C. THORNTON JOHNSON M00582

22. Name and Address of Facility

THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON RD INDIAN HEAD, MD 2064023a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Cardiopulmonary Arrest

e. Due to (or as a consequence of):

b. Lung Cancer + Metastasis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Collins P. Sein

29c. License number

D46979

29d. Date signed (Month, Day, Year)

11/5/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Collins P. Sein, MD 605 East Charles Street La Plata, Maryland 20646

31. Date filed (Month, Day, Year)

NOV 08 1999

32. Registrar's Signature

Geneva B. Sparks

State
RegistrarJoseph Gooseberry
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36128

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) William T. Gray | | | | 2. Date of Death Month Day Year November 3, 1999 | | 3. Time of Death 6:45 PM | |
| | 4a. Facility Name (If not institution, give street and number) 7901 Pats Lane | | | | 4b. City, Town, or Location of Death Fort Washington | | 4c. County of Death Prince Georges | |
| Funeral Director | 5. Social Security Number 577-18-4709 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (in yrs. last birthday) 87 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) August 25, 1912 | |
| | 9. Birthplace (State or Foreign Country) Virginia | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | |
| | 10a. State Maryland | | 10b. County Prince Georges | | 10c. City, Town or Location Fort Washington | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 7901 Pats Lane | | | | 10f. Zip Code 20744 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 Collega (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cremator | | 16b. Kind of Business/Industry Cemetery/Crematory | |
| | 17. Father's Name (First, Middle, Last) Melvin Gray | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ada Ennis | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Joseph W. Gray/son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7901 Pats Ln., Ft. Washington, MD 20745 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | 20c. Location - City or Town, State 11/4/1999 Alexandria, VA | | | |
| | 21. Signature of Funeral Service Licensee George P. Kalas | | | | 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) a. metastatic prostate cancer | | | | Due to (or as a consequence of): | | | |
| | b. Due to (or as a consequence of): | | | | | | | |
| | c. Due to (or as a consequence of): | | | | | | | |
| | d. Due to (or as a consequence of): | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Approximate Interval Between Onset and Death 18 months | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how Injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier D.J. Haidak MD | | | | 29c. License number D-17605 | | 29d. Date signed (Month, Day, Year) 11/4/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D.J. Haidak MD 8926 Woodyard Rd. #201 Clinton, Md. 20735 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 05 1999 | | | | 32. Registrar's Signature B. [Signature] | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36129

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Ann Lilly Green

2. Date of Death
Month Day Year
October 31, 19993. Time of Death
2:55 AM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore, City

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

578-52-6824

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Aug. 12, 1916

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD.

10b. County

Prince Georges

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

10610 Excalibur Road #A407

10f. Zip Code

20716

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Fred Lilly

18. Mother's Name (First, Middle, Maiden Surname)

Addie Hanks Hearn Lilly

19a. Informant's Name/Relationship (Type, Print)

Roy Green/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10610 Excalibur Rd. #A407 Bowie, Md. 20716

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Resurrection Cem. 11-6-99

Date

20c. Location - City or Town, State

Clinton, Md.

21. Signature of Funeral Service Licensee

Shannon W. Beall
Shannon W. Beall M00798

22. Name and Address of Facility

Beall Funeral Home
6512 N.W. Crain Highway Bowie, Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Obstructive Jaundice

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Obstructive Jaundice

Due to (or as a consequence of):

Klatskin Tumor

c. Klatskin Tumor

Due to (or as a consequence of):

d.

Approximate interval Between Onset and Death

2 weeks

months

months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jonathan M. Gerber, M.D.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

October 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan M. Gerber 600 N Wolfe St Baltimore, MD 21287

31. Date filed (Month, Day, Year)

NOV 05 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

ORIGINAL

Handwritten signature or initials.

Page 2 of 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36130

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Funeral
Director

Physician
/Medical
Examiner

| | | | | | | | | | | | | | |
|---|--|---|---|--|--------------------------------|---|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Bernard Hardy III | | | | 2. Date of Death Month Day Year NOVEMBER 04 1999 | | | | 3. Time of Death 2335 | | | | | |
| 4a. Facility Name (If not institution, give street and number) NORTH OF 2607 BELAIR RD. | | | | 4b. City, Town, or Location of Death BELAIR | | | | 4c. County of Death HARFORD | | | | | |
| 5. Social Security Number 214-88-4678 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 36 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) October 5, 1963 | | 9. Birthplace (State or Foreign Country) Maryland | | | | | |
| Usual Residence of Decedent | | | | 10a. State Maryland | | | | 10b. County Harford | | 10c. City, Town or Location Bel Air | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 211 Broadview Avenue | | | | 10f. Zip Code 21014 | | | | 10g. Citizen of What Country? United States | | | | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpet Layer | | | | 16b. Kind of Business/Industry Bill's Carpet Retail Carpet Store | | | | | |
| 17. Father's Name (First, Middle, Last) Bernard Hardy, Jr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Christine Noto | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Judy A. Dean / Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2575 Turkey Point Road, North East, Maryland 21901 | | | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadow Ridge Memorial Park | | Date November 8, 1999 | | 20c. Location - City or Town, State Elk Ridge, Maryland | | | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Head and Chest Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | | | | 24a. Was an autopsy performed? Inspection 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month/Day/Year) 11/4/99 | | 28b. Time of Injury 2256 M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Pedestrian struck by motor vehicle | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street; Belair Rd; Harford County, Md. | | | | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) NOVEMBER 05, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 08 1999 | | 32. Registrar's Signature | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36131**
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---------------------------------|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Nelson L. Johnson | | | | 2. Date of Death Month November Day 3 , Year 1999 | | 3. Time of Death 10:55 am | |
| | 4a. Facility Name (If not institution, give street and number) Bayside Nursing Center | | | | 4b. City, Town, or Location of Death Lexington Park | | 4c. County of Death St. Mary's | |
| Funeral Director | 5. Social Security Number 213-40-8462 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 58 Yrs. | | 8. Date of Birth (Month, Day, Year) February 3, 1941 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10. Usual Residence of Decedent | | 10a. State Maryland | | 10b. County Charles | |
| 10c. City, Town or Location Nanjemoy | | 10d. Inside City Limits 1 Yes 2 No | | 10e. Street and Number 13200 Riverside Road | | 10f. Zip Code 20662 | | |
| 10g. Citizen of What Country? United States | | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) College (1-4 or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | 16b. Kind of Business/Industry Construction | | |
| 17. Father's Name (First, Middle, Last) Lana Gaina | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lucy Johnson | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Roland R. Butler, Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13070 Riverside Road, Nanjemoy, MD 20662 | | | | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oakgrove Church Cemetery | | 20c. Date 11-6-99 | | 20d. Location - City or Town, State Nanjemoy, Maryland | | |
| 21. Signature of Funeral Service Licensee Ronald L. Thompson, Jr., M01154 | | | | 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650-0279 | | | | |
| 23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Carcinoma Oropharynx Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | |
| Approximate Interval Between Onset and Death months | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | |
| 24a. Was an autopsy performed? 1 Yes 2 No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | |
| 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | |
| 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | | | 29c. License number D19917 | | 29d. Date signed (Month, Day, Year) 11/4/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James C. Boyd, MD, 23415 Three Notch Rd., California, Maryland 20619 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 08 1999 | | | | 32. Registrar's Signature [Signature] | | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36132

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Herbert Morris Johnson, III

2. Date of Death

November 4 1999

3. Time of Death

6:09 am

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

579-72-8832

6. Sex

M 20 F

7. Age (In yrs. last birthday)

43

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

February 7, 1956

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

500 Gerry Court

10f. Zip Code

20602

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Alarm Installer

16b. Kind of Business/Industry

Alarm Company

17. Father's Name (First, Middle, Last)

Herbert M. Johnson, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Barbara M. Thomas

19a. Informant's Name/Relationship (Type, Print)

Herbert M. Johnson, Jr./Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8265 Warren Drive, Pomfret, Maryland 20675

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Trinity Memorial Gardens

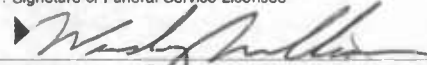
Date

November 9, 1999

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee


MO0668

22. Name and Address of Facility

Williams Funeral Home, P.A.
4270 Hawthorne Road, Indian Head, Maryland 20640

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cardiopulmonary arrest
Due to (or as a consequence of):
Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier



29c. License number

D46979

29d. Date signed (Month, Day, Year)

11/5/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Collins P. Sein, MD 605 East Charles Street La Plata, Maryland 20646

State
Registrar

31. Date filed (Month, Day, Year)

NOV 08 1999

32. Registrar's Signature



To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Herbert M. Johnson
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36133

AMEND#23A & 27 PER M.E.O. G777 11-22-99 J.A.

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Baron Arnell Jones | | | | 2. Date of Death Month Day Year OCTOBER 30, 1999 | | 3. Time of Death 0429 AM | |
| | 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death WICOMICO | |
| Funeral Director | 5. Social Security Number 218-90-5072 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 31 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 09, 1968 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Dorchester | | 10c. City, Town or Location Cambridge | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 502 Dobson Street | | 10f. Zip Code 21613 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter | | 16b. Kind of Business/Industry Construction | | | | |
| 17. Father's Name (First, Middle, Last) Alvin O'Donnell Jones | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret A. Smith | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Margaret Jones | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 Dobson Street Cambridge, Maryland 21613 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Peter's Church Cemetery | | 20c. Location - City or Town, State 11/04/99 Church Creek, Maryland | | | | |
| 21. Signature of Funeral Service Licensee Janelle C. Skewy | | 22. Name and Address of Facility HENRY FUNERAL HOME P.A. 510 Washington St. Cambridge, Maryland 21613 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEIZURE DISORDER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier [Signature] | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) OCTOBER 30, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Fowler, M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 02 1999 | | 32. Registrar's Signature [Signature] | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36134

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elles Lee Kornegay

2. Date of Death

November 2, 1999

3. Time of Death

11:50 P.M.

4a. Facility Name (If not institution, give street and number)

VA MEDICAL CENTER, FORT HOWARD MD 21052

4b. City, Town, or Location of Death

FORT HOWARD

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

230-50-6194

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

7-12-25

9. Birthplace (State or Foreign Country)

Wayne Cty., N.C.

Usual Residence of Decedent

10a. State

Virginia

10b. County

10c. City, Town or Location

Alexandria

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8423 Mina Loma Ct.

10f. Zip Code

22309

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Willie Kornegay

18. Mother's Name (First, Middle, Maiden Surname)

Quessie Barfield

19a. Informant's Name/Relationship (Type, Print)

Doreatha J. Major/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8411 Alameda Ct. Alexandria, Va. 22309

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Durham Family Cemetery

Date

11/8/99

20c. Location - City or Town, State

Mt. Olive, N.C.

21. Signature of Funeral Service Licensee

Keith A. Sarge M1085

22. Name and Address of Facility

Alexander S. Pope Funeral Homes

5538 Marlboro Pike/Forestville, Md.

20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Prostate Carcinoma

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

6 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Multiple Bone Metastasis

Due to (or as a consequence of):

6 years

c. Anemia

Due to (or as a consequence of):

years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Augustin Chyu, M.D.

29c. License number

D-13298

29d. Date signed (Month, Day, Year)

11/3/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUGUSTIN CHYU, M.D., VA MEDICAL CENTER, FORT HOWARD, MARYLAND 21052

31. Date filed (Month, Day, Year)

NOV 05 1999

32. Registrar's Signature

[Signature]

State
Registrar

AKA: Kornegay, Elles

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.
To the Medical Examiner: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36135

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DONALD EDWIN Leedom

2. Date of Death

Nov. 6, 1999

Day

Year

3. Time of Death

6:10 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

ELKTON

4c. County of Death

Cecil

5. Social Security Number

218-28-4905

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jul 19, 1931

9. Birthplace (State or Foreign Country)

U.S.A.

Usual Residence of Decedent

10a. State

MD.

10b. County

Cecil

10c. City, Town or Location

ELKTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

399 DEADER ROAD

10f. Zip Code

21921

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

MASTER ELECTRICIAN

16b. Kind of Business/Industry

ELECTRICAL

17. Father's Name (First, Middle, Last)

Harvey L. Leedom

18. Mother's Name (First, Middle, Maiden Surname)

EDNA WALTHER

19a. Informant's Name/Relationship (Type, Print)

EVELYN Leedom - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

399 DEADER ROAD - ELKTON MD 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

ELKTON CEMETERY

Date

11/10/1999

20c. Location - City or Town, State

ELKTON MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Gee Funeral Home 259 E. MAIN ST

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

acute myocardial infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30 min

b.

Colon perforation

Due to (or as a consequence of):

10 days

c.

Pneumonia

Due to (or as a consequence of):

14 days

d.

COPD, sepsis.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jui Chin Hsu MD

29c. License number

D04823

29d. Date signed (Month, Day, Year)

11/6/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUI CHIN HSU 223 West main st. Elkton MD 21921

31. Date filed (Month, Day, Year)

NOV 08 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36136

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Richard Leroy LaPointe | | | | 2. Date of Death Month November Day 3 Year 1999 | | 3. Time of Death 03 33 | |
| | 4a. Facility Name (If not institution, give street and number) Union Hospital of Cecil County | | | | 4b. City, Town, or Location of Death Elkton | | 4c. County of Death Cecil | |
| Funeral Director | 5. Social Security Number 214-92-3480 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 38 Yrs. | | 8. Date of Birth (Month, Day, Year) January 14, 1961 | |
| | 9. Birthplace (State or Foreign Country) Delaware | | 10a. State Maryland | | 10b. County Cecil | | 10c. City, Town or Location Elkton | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 37 Pine Grove Lane | | 10f. Zip Code 21921 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Never worked | | 16b. Kind of Business/Industry n/a | | 17. Father's Name (First, Middle, Last) Robert G. LaPointe | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Virginia L. Bush | | 19a. Informant's Name/Relationship (Type, Print) Virginia L. Adams/ mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 Pine Grove Lane, Elkton, Maryland 21921 | | 20. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| Physician /Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris and Company | | 20c. Location - City or Town, State West Chester, Pennsylvania | | 21. Signature of Funeral Service Licensee Donna S. Hicks | | 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Massive Myocardial Infarction Due to (or as a consequence of): b. Ischemic Cardiomyopathy Due to (or as a consequence of): c. Non Insulin Dependent Diabetes Mellitus Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death Minutes Years Years | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Seizures Down's Syndrome | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once. | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| | 29b. Signature and title of certifier M.D. | | 29c. License number D0047711 | | 29d. Date signed (Month, Day, Year) November 4, 1999 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DAVID GAR-EL 3 MAULBIN AVENUE NORTH EAST MARYLAND 21901 | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 05 1999 | | 32. Registrar's Signature B. Sparks | | 33. Registrar's Title Registrar | | 34. Registrar's Office State Registrar | |

1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36137

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Margaret Marie Meekins | | | | 2. Date of Death Month November Day 5 Year 1999 | | 3. Time of Death 0021 | |
| | 4a. Facility Name (If not institution, give street and number) Union Hospital of Cecil County | | | | 4b. City, Town, or Location of Death Elkton | | 4c. County of Death Cecil | |
| Funeral Director | 5. Social Security Number 235-58-3111 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 61 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) November 14, 1937 | 9. Birthplace (State or Foreign Country) West Virginia |
| | Usual Residence of Decedent | | | | 10a. State Maryland | | 10b. County Cecil | |
| 10c. City, Town or Location Elkton | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 10e. Street and Number 13 Manassas Drive | | | | 10f. Zip Code 21921 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 Collage (1-4or 5+) 10 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress | | 16b. Kind of Business/Industry Elkton Moose Lodge | | |
| 17. Father's Name (First, Middle, Last) Lawrence Meadows | | | | 18. Mother's Name (First, Middle, Maiden Surname) Phoebie Bryant | | | | |
| 19e. Informant's Name/Relationship (Type, Print) Eugene L. Meekins / Spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Manassas Drive, Elkton, Maryland 21921 | | | | |
| 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) North East Methodist Cemetery | | Date November 9, 1999 | | 20c. Location - City or Town, State North East, Maryland |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | e. acute myocardial infarction Due to (or as a consequence of): Hypertension | | | | Approximate Interval Between Onset and Death 2 hrs |
| | | | | b. Perfused vascular insufficiency Due to (or as a consequence of): | | | | 10 yrs |
| | | | | c. Perfused vascular insufficiency Due to (or as a consequence of): | | | | |
| | | | | d. Perfused vascular insufficiency Due to (or as a consequence of): | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | |
| | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how Injury occurred | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Jeri Chaz Han MD | | 29c. License number 204823 | | 29d. Date signed (Month, Day, Year) 11/5/99 |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JULIAN HAN MD 223 West main st, Elkton MD 21921 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 08 1999 | | | | 32. Registrar's Signature | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36138

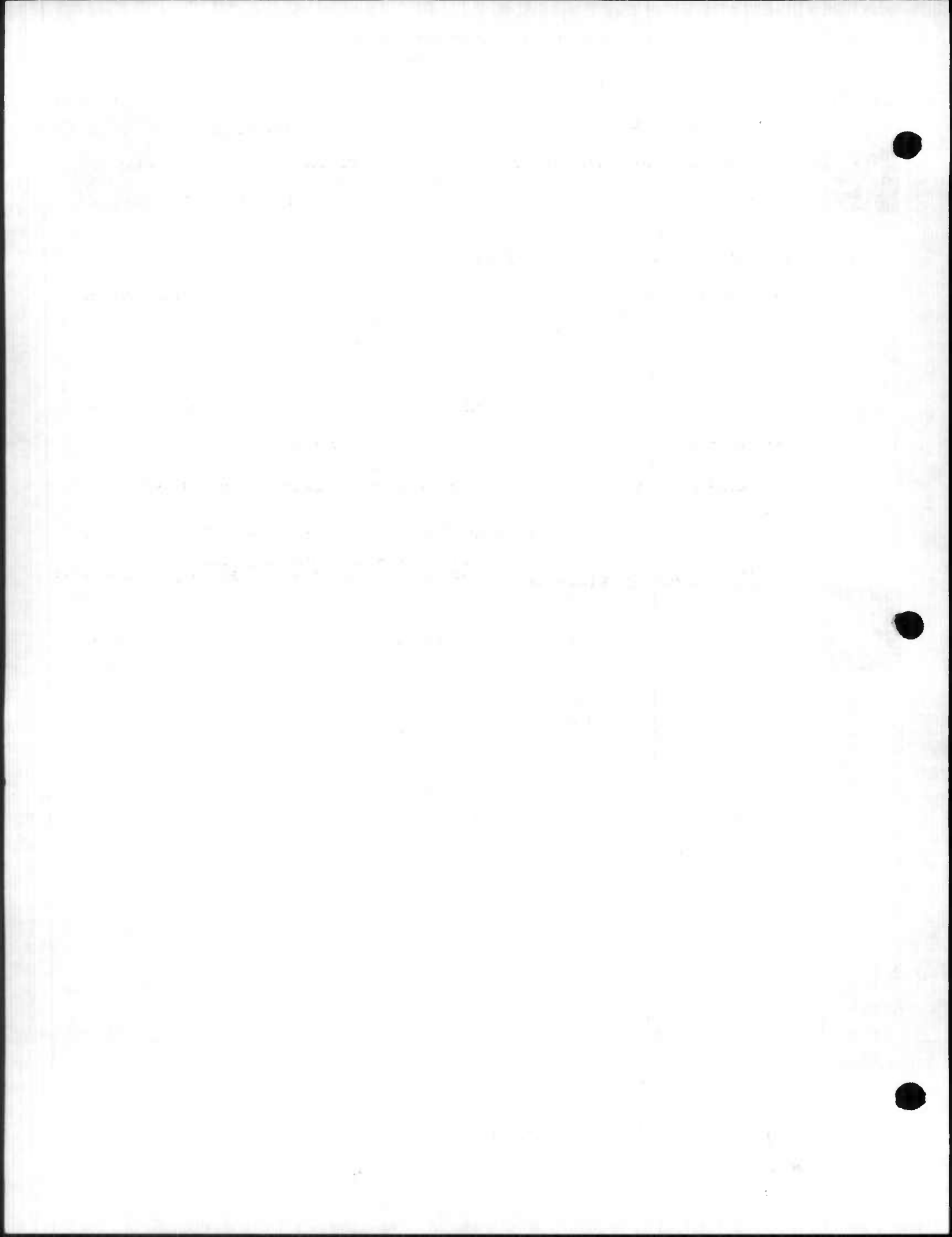
Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | |
|--|--|---|---|--|--|---|--|---|---|---|---|---|---|---------------|--|--------------|----|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John Eugene Manning | | | | 2. Date of Death Month November Day 2 Year 1999 | | 3. Time of Death 0902 | | | | | | | | | | |
| | 4e. Facility Name (If not institution, give street and number) Union Hospital of Cecil County | | | | 4b. City, Town, or Location of Death Elkton | | 4c. County of Death Cecil | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 218-05-5448 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 82 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) October 21, 1917 | 9. Birthplace (State or Foreign Country) Delaware | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Cecil | | 10c. City, Town or Location Elkton | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| | 10e. Street and Number 215 Maloney Road | | | | 10f. Zip Code 21921 | | 10g. Citizen of What Country? United States | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver | | 16b. Kind of Business/Industry Transportation | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) John Manning | | | | 18. Mother's Name (First, Middle, Maiden Surname) Emma Reed | | | | | | | | | | | | |
| | 19e. Informant's Name/Relationship (Type, Print) Annabelle Manning/ wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 Maloney Road, Elkton, Maryland 21921 | | | | | | | | | | | | |
| | 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gilpin Manor Memorial Park | | Date 11/5/99 | | 20c. Location - City or Town, State Elkton, Maryland | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921 | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td rowspan="4">{</td> <td>e. Multi Organ Failure Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death Week</td> </tr> <tr> <td>b. Infectious Endocarditis Due to (or as a consequence of):</td> <td>Months</td> </tr> <tr> <td>c. Cardiomyopathy Due to (or as a consequence of):</td> <td>Years</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | { | e. Multi Organ Failure Due to (or as a consequence of): | Approximate Interval Between Onset and Death Week | b. Infectious Endocarditis Due to (or as a consequence of): | Months | c. Cardiomyopathy Due to (or as a consequence of): | Years | d. |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | { | e. Multi Organ Failure Due to (or as a consequence of): | Approximate Interval Between Onset and Death Week | | | | | | | | | | | | | | |
| | | b. Infectious Endocarditis Due to (or as a consequence of): | Months | | | | | | | | | | | | | | |
| | | c. Cardiomyopathy Due to (or as a consequence of): | Years | | | | | | | | | | | | | | |
| | | d. | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia of Alzheimer Type Renal failure | | | | | | 23b. Did tobacco use contribute to the causes of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | 29c. License number D23322 | | 29d. Date signed (Month, Day, Year) 11.3.99 | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) S.S. SACHDEV MD. 118 North St, Suite 303, Elkton MD 21921 | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 05 1999 | | 32. Registrar's Signature  | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Amended Item#1 perPhyG781 3/3/2000 EW

99 36139

| | | | | | | | | |
|--|---|---|--|---|--|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Helen Pauline Metheny | | | | 2. Date of Death Month 11 Day 05 Year 99 | | 3. Time of Death 11:30 AM | |
| | 4a. Facility Name (If not institution, give street and number) 531 University Drive | | | | 4b. City, Town, or Location of Death Waldorf | | 4c. County of Death Charles | |
| Funeral Director | 5. Social Security Number 234-20-5037 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Nov 09, 1920 | 9. Birthplace (State or Foreign Country) West Virginia |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Charles | | 10c. City, Town or Location Waldorf | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 531 University Drive | | | | 10f. Zip Code 20602 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Book Keeper/Secretary | | | 16b. Kind of Business/Industry Government | |
| 17. Father's Name (First, Middle, Last) MacDonald Keeney | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mamie Stanley Keeney | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Judith K. Lindley/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 531 University Dr. Waldorf, MD 20602 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Witcher Cemetery | | Date 11/10/99 | | 20c. Location - City or Town, State Belle, West Virginia |
| 21. Signature of Funeral Service Licensee M00817 <i>Gayton C. Echols III</i> | | | | 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A. P.O. Box 567 La Plata, MD 20646 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Lung Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier <i>Kevin M. Matten</i> | | 29c. License number D28352 | | 29d. Date signed (Month, Day, Year) 11-5-99 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P O Box 1703 La Plata Md 20646 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 09 1999 | | | | 32. Registrar's Signature <i>Geneva B. Sparks</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36140

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Robert Miller | | | | 2. Date of Death Month Day Year November 2, 1999 | | 3. Time of Death 8:30am | |
| | 4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital | | | | 4b. City, Town, or Location of Death Clinton | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 578-54-9458 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 57 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 3, 1942 | |
| | 9. Birthplace (State or Foreign Country) Charlotte, N.C. | | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Suitland | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State Maryland | | | 10b. County Prince George's | | | 10c. City, Town or Location Suitland | | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 10e. Street and Number 3115 Lassie Ave. | | | 10f. Zip Code 20746 | | |
| 10g. Citizen of What Country? United States | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Technician | | | 16b. Kind of Business/Industry Private | | | 17. Father's Name (First, Middle, Last) Frank James | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Ruth Miller | | | 19a. Informant's Name/Relationship (Type, Print) Lorraine Miller/Wife | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3115 Lassie Ave. Suitland, Md. 20746 | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Cemetery | | | 20c. Location - City or Town, State 11/8/99 Suitland, Md. | | |
| 21. Signature of Funeral Service Licensee Katha Sarge Miller | | | 22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747 | | | 23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic Prostate Cancer 4 years Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how Injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Bob Radjare | | | 29c. License number 039691 | | | 29d. Date signed (Month, Day, Year) 11/4/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bob Radjare MD 4467 Old Branch Ave. Temple Hills, Md. 20748 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 05 1999 | | | 32. Registrar's Signature S. Sarge | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Submit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36141

| | | | | | | | | | | |
|---|---|--|---|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James Henry Moore | | | | 2. Date of Death Month Day Year November 1, 1999 | | | | 3. Time of Death 8:15 am | |
| | 4a. Facility Name (If not institution, give street and number) 513 71st Street | | | | 4b. City, Town, or Location of Death Seat Pleasant | | | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 579-52-0043 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 58 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 16, 1940 | | 9. Birthplace (State or Foreign Country) Pennsylvania | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Seat Pleasant | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 513 71st Street | | | | 10f. Zip Code 20743 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Glass Mechanic | | | | 16b. Kind of Business/Industry Thompson's Glass Co. | | | |
| | 17. Father's Name (First, Middle, Last) Thomas Walker Moore | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elsie Mae Masterson | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Charlotte I. Moore - Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 513 71st Street, Seat Pleasant, Maryland 20743 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Washington National Cemetery | | Data 11/06/99 | | 20c. Location - City or Town, State Suitland, Maryland | | | |
| | 21. Signature of Funeral Service Licensee <i>Carly Lynn Gasch-Brady</i> | | | | 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Oropharyngeal Carcinoma, stage IV</i> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Sepsis</i> | | | | | | | | | |
| State Registrar | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <i>Duane Taylor</i> | | 29c. License number D0040031 | | 29d. Date signed (Month, Day, Year) November 1, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Duane Taylor, M.D., 1221 Mercantile Lane, Largo, Maryland 20743 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) NOV 05 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

104 02 100

99-6735-031

99-267

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: #23 PART I State of Maryland / Department of Health and Mental Hygiene
Doretha Elizabeth McDonald 27, PER MEO G777/11/18-99 WR.

Certificate of Death

Reg. No.

99 36142

| | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Doretha Elizabeth McDonald | | | | 2. Date of Death Month Day Year NOVEMBER 9, 1999 | | 3. Time of Death 10:38A.M. | | |
| | 4a. Facility Name (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death SILVER SPRING | | 4c. County of Death MONTGOMERY | | |
| Funeral Director | 5. Social Security Number 577-54-3816 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 64 Yrs. | | 8. Date of Birth (Month, Day, Year) 11-15-1934 | | |
| | 9. Birthplace (State or Foreign Country) TROY, N.C. | | 10a. State MD | | 10b. County PRINCE GEORGE'S | | 10c. City, Town or Location ADELPHI | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| 10a. Street and Number 1804 METZEROTT ROAD, #401 | | | | 10f. Zip Code 20783 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNEMPLOYED | | 16b. Kind of Business/Industry N/A | | | |
| 17. Father's Name (First, Middle, Last) NASH THOMAS | | | | 18. Mother's Name (First, Middle, Maiden Surname) SADIE LEDWELL | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) LORETTA KALIFA - DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 331 54th STREET, NE WASH.DC 20019 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) FOREST HILLS MEM.GAR.20-1999 | | 20c. Location - City or Town, State CLINTON, MD | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH.DC 20001 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIOMEGALY Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) NOVEMBER 10, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. S. Nelson, D. KOBOW M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 15 1999 | | | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1000 2 1 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36143

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

STELLA MARIE McFADDEN

2. Date of Death

Nov. 12, 1999 10:38 am

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

Anne Arundel

5. Social Security Number

266-32-7498

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Sept. 1, 1923 W. Virginia

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland Anne Arundel

10b. County

10c. City, Town or Location

Cape St. Claire

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

460 Man O'War Court

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Cafeteria Chef

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

Ralph Alberts

18. Mother's Name (First, Middle, Maiden Surname)

Grace

19a. Informant's Name/Relationship (Type, Print)

Cathy J. Cowman / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10600 Davis Ave., C-1 Woodstock, MD 21163

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Howard U. Coll. of Med. 11/12/99 Wash., DC

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lincoln & Lincoln Funeral Service
4315 Anacostia Av., NE Wash., DC 2001923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. BILATERAL PNEUMONIA

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

ONE WEEK

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEVERE CHRONIC OBSTRUCTIVE LUNG DISEASE

CHRONIC LYMPHOCYTIC LEUKEMIA

INSULIN DEPENDENT DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D38328

29d. Date signed (Month, Day, Year)

11/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY R CLANCE 180 ADMIRAL COCHRANE DR ANNAPOLIS MD

State
Registrar

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

21401

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

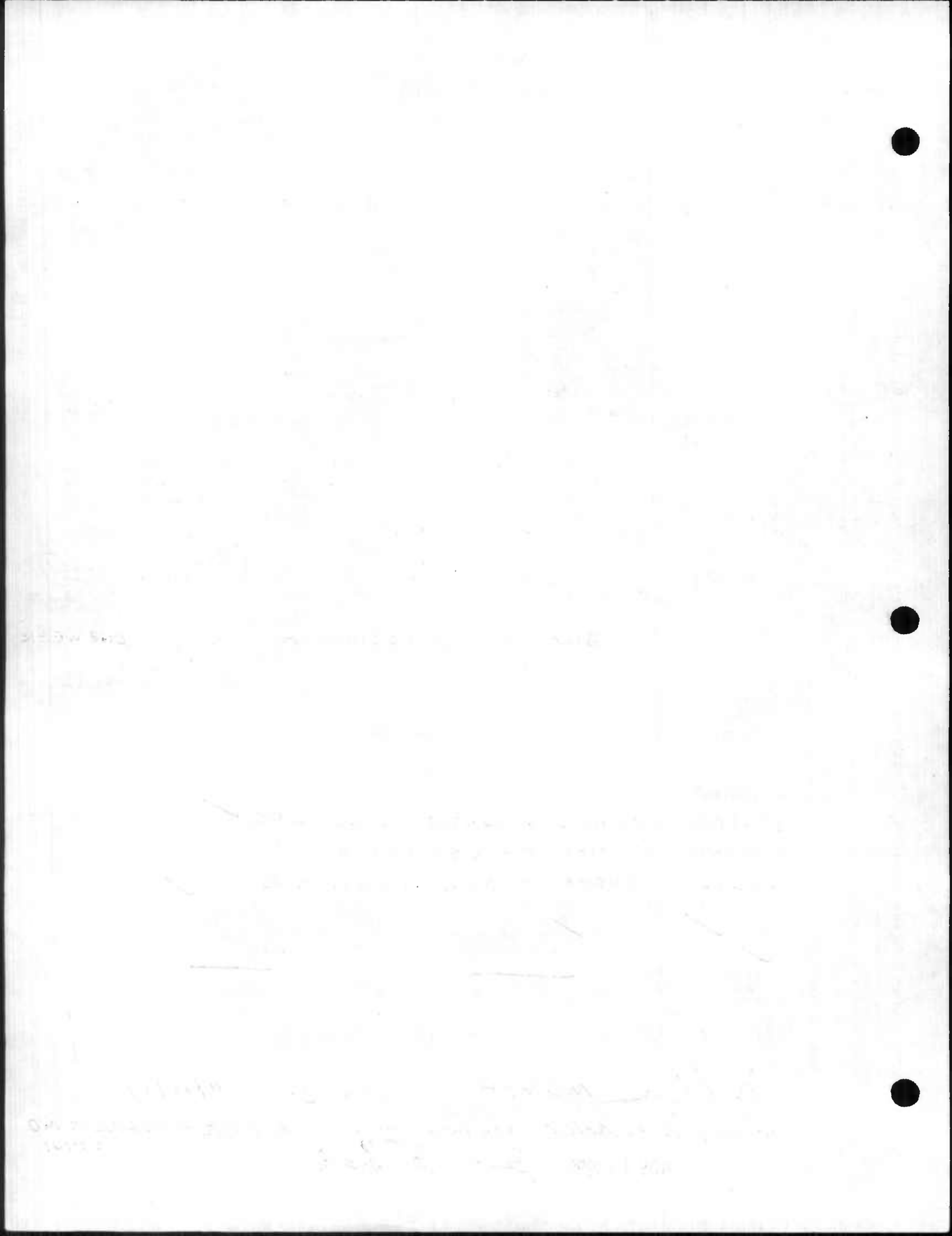
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-358-2000.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36144

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|---|--|---|---|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Walter Preston Mills, Jr. | | | | 2. Date of Death Month <u>10</u> Day <u>30</u> Year <u>1999</u> | | 3. Time of Death 6:30 AM | |
| 4a. Facility Name (If not institution, give street and number) Chesapeake Woods Center | | | | 4b. City, Town, or Location of Death Cambridge | | 4c. County of Death Dorchester | |
| 5. Social Security Number 215-26-3925 | | 6. Sex 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 80 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 29, 1919 | 9. Birthplace (State or Foreign Country) Maryland |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Dorchester | | 10c. City, Town or Location Cambridge | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 5102 Beaver Neck Village Road | | | | 10f. Zip Code 21613 | | 10g. Citizen of What Country? US | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11</u> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer | | 16b. Kind of Business/Industry Agriculture | |
| 17. Father's Name (First, Middle, Last) Walter Preston Mills, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lena Horseman | | | |
| 19a. Informant's Name/Relationship (Type, Print) Walter P. Mills III Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5104 Beaver Neck Village Rd Cambridge, MD 21613 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dorchester Memorial Park | | Date 11/2/99 | | 20c. Location - City or Town, State Cambridge, Maryland | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Pneumonia</u> Due to (or as a consequence of): b. <u>Chronic Pulmonary Disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death <u>2 wks</u> <u>10 yrs</u> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Osteoporosis</u> | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D26388 | | 29d. Date signed (Month, Day, Year) 11-1-99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael F. Fadden, MD 302 Collins Avenue Hurlock, Maryland 21643 | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 02 1999 | | | | 32. Registrar's Signature | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

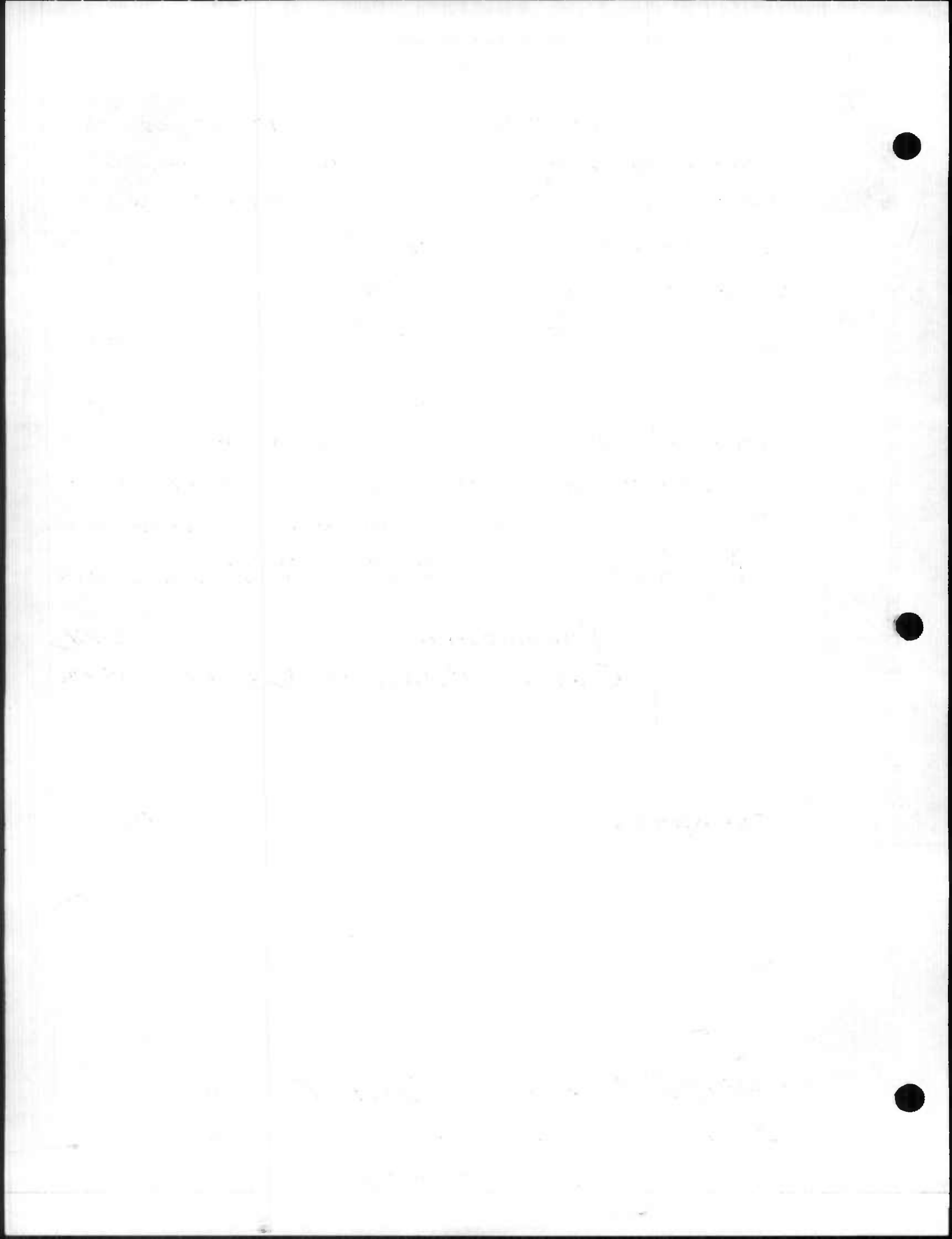
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36145

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|---|--|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CHARLES DANIEL ROGERS | | | | 2. Date of Death Month Day Year November 4, 1999 | | 3. Time of Death 7:10 AM | | |
| | 4a. Facility Name (If not institution, give street and number) Civista Medical Center | | | | 4b. City, Town, or Location of Death La Plata | | 4c. County of Death Charles | | |
| Funeral Director | 5. Social Security Number 217-42-0008 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 57 Yrs. | | 8. Date of Birth (Month, Day, Year) July 31, 1942 | | |
| | 9. Birthplace (State or Foreign Country) Washington, DC | | 10a. State Maryland | | 10b. County Charles | | 10c. City, Town or Location Waldorf | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 2980 Double R Road | | 10f. Zip Code 20603 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1964-1965 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assistant Chief Engineer | | 16b. Kind of Business/Industry Operations/Maintenance | | | | | |
| 17. Father's Name (First, Middle, Last) Thomas Stewart Rogers | | | | 18. Mother's Name (First, Middle, Maiden Surname) Charlotte Ruth Dinsmore | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Brenda F. Rogers/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2980 Double R Road, Waldorf, Maryland 20603 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Huntt Crematory | | Date 11-08-1999 | | 20c. Location - City or Town, State Waldorf, Maryland | | | |
| 21. Signature of Funeral Service Licensee MARK G. BROHAWN M00053 | | 22. Name and Address of Facility Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156, | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | e. Cardiorespiratory arrest Due to (or as a consequence of): b. Hepatorenal syndrome Due to (or as a consequence of): c. Ascites Due to (or as a consequence of): d. Acute Renal failure | | Approximate Interval Between Onset and Death | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Dr. Waheed Akhtar | | 29c. License number D31675 | | 29d. Date signed (Month, Day, Year) 4 Nov 99 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Waheed Akhtar, P. O. Box 1737, White Plains, MD 20695 | | 31. Date filed (Month, Day, Year) NOV 09 1999 | | 32. Registrar's Signature B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



State of Maryland / Department of Health and Mental Hygiene

99 36146

ITEM #26 AS PER DOCTOR 11/9/99 CCHD FCB

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|--|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOAN CROMAR PIPES | | | | 2. Date of Death Month Day Year NOVEMBER 7, 1999 | | 3. Time of Death 8:30 AM | |
| | 4a. Facility Name (If not institution, give street and number) 8425 Welcome Woods Place | | | | 4b. City, Town, or Location of Death Welcome | | 4c. County of Death Charles | |
| Funeral Director | 5. Social Security Number 213-30-5837 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 67 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 14, 1932 | | 9. Birthplace (State or Foreign Country) Washington DC |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Charles | | 10c. City, Town or Location Welcome | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 8425 Welcome Woods Place | | | | 10f. Zip Code 20693 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Secretary | | | 16b. Kind of Business/Industry Prince George's County School System | |
| 17. Father's Name (First, Middle, Last) Theodore Robb Cromar | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary W. Bryant | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Timothy M. Eagan-Son in law | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30080 Bow Court, Mechanicsville, MD 20659 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans' Cem. | | Date 11-12-99 | | 20c. Location - City or Town, State Cheltenham, MD | | |
| 21. Signature of Funeral Service Licensee  John P. Knisley MD164 | | | | 22. Name and Address of Facility Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC GASTRIC CARCINOMA Due to (or as a consequence of): b. SEVERE MALNUTRITION Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death Expired at 8:30 AM on 11/7/99 |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  Salish Humani, M.D. | | | | 29c. License number D35295 | | 29d. Date signed (Month, Day, Year) 11/8/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 ST. PATRICKS DR. SUITE 208, WALDORF, MD 20603 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 09 1999 | | 32. Registrar's Signature  | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

JOAN C. PIPES

Baltimore, Maryland 21215-0020

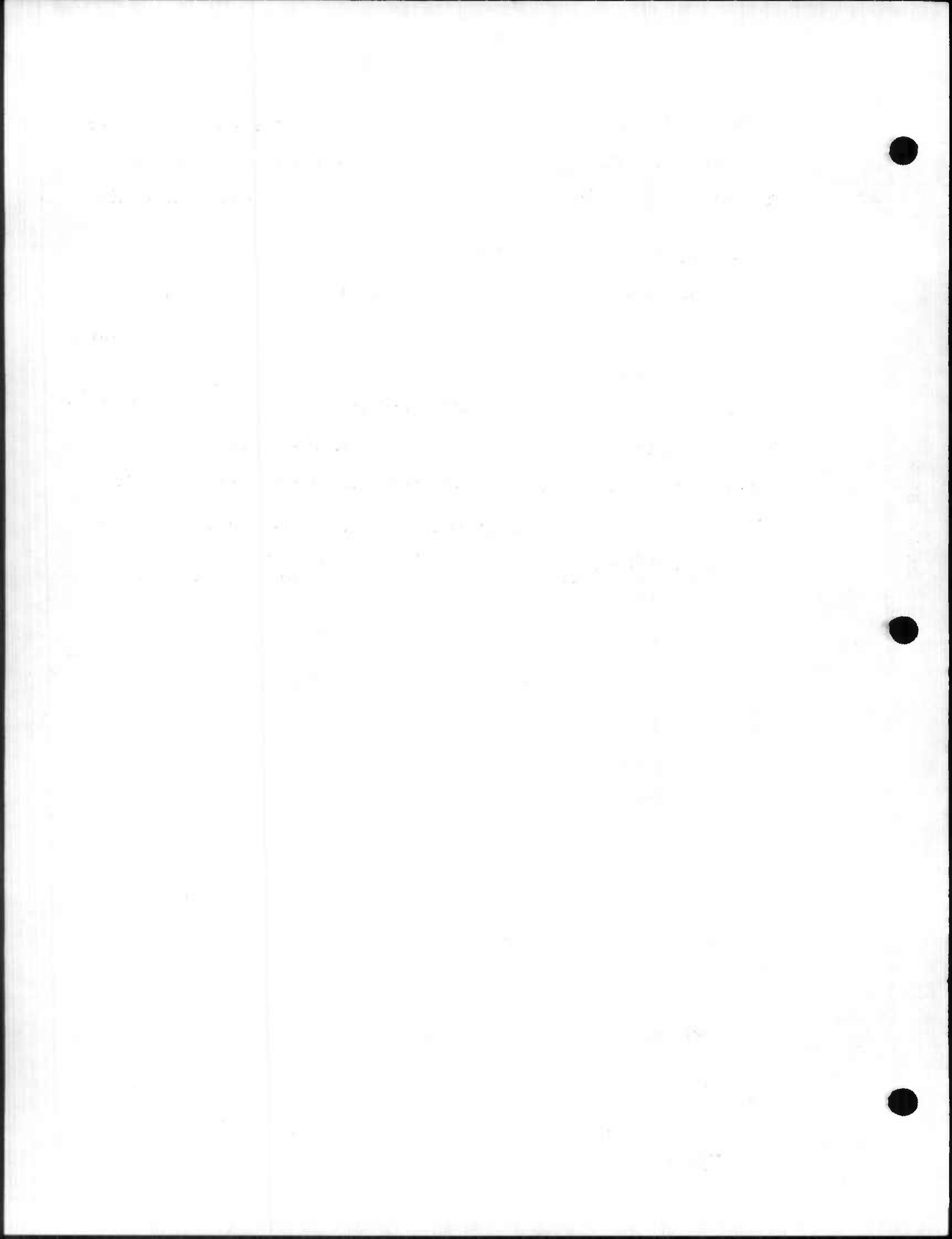
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36147

| | | | | | |
|--|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Benjamin J. Rious Sr. | | 2. Date of Death Month Day Year NOVEMBER 1, 1999 | | 3. Time of Death 9:50 am |
| | 4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL | | 4b. City, Town, or Location of Death SILVER SPRING | | 4c. County of Death MONTGOMERY |
| Funeral Director | 5. Social Security Number 240-09-9081 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | Usual Residence of Decedent | | 8. Date of Birth (Month, Day, Year) JULY 9, 1921 | | 9. Birthplace (State or Foreign Country) SOUTH CAROLINA |
| To Be Completed by Funeral Director | 10a. State | 10b. County | 10c. City, Town or Location WASHINGTON, D.C. | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number 5113 13th ST N.W. | | 10f. Zip Code 20011 | | 10g. Citizen of What Country? UNITED STATES OF AMERICA |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MAINTENANCE SUPERVISOR | | 16b. Kind of Business/Industry PRIVATE INDUSTRY |
| | 17. Father's Name (First, Middle, Last) BENJAMIN RIOUS | | 18. Mother's Name (First, Middle, Maiden Surname) ETTA (UNKNOWN) | | |
| | 19a. Informant's Name/Relationship (Type, Print) ERMA RIOUS / WIFE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5113 13th ST NW WASHINGTON DC 20011 | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND NATIONAL CEMETERY | | 20c. Location - City or Town, State BELTSVILLE, MARYLAND |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility JOHNSON & JENKINS FUNERAL HOME 716 KENNEDY ST NW WDC 20011 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| | Approximate Interval Between Onset and Death | | | | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) | | | | |
| | e. CARDIOPULMONARY ARREST Due to (or as a consequence of): | | | | |
| | b. ASPIRATION PNEUMONIA Due to (or as a consequence of): | | | | |
| | c. BOWEL OBSTRUCTION Due to (or as a consequence of): | | | | |
| | d. | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | OBSTRUCTIVE UROPATHY | | | | |
| | CVA with APHASIA | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number D52251 | | 29d. Date signed (Month, Day, Year) NOVEMBER 2, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALAN R. SEGAL 1209 Lambertson Dr. Silver Spring MD 20902 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 04 1999 | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27 PER MEO

Certificate of Death

Reg. No.

99 36148

| | | | | | | | | | |
|---|---|--|---|---|--|--|---|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ORLANDO SEAN ROYSTER | | | | 2. Date of Death Month Day Year November 11 1999 | | 3. Time of Death 06:13 PM. | | |
| | 4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center | | | | 4b. City, Town, or Location of Death Cheverly | | 4c. County of Death Prince George's | | |
| Funeral Director | 5. Social Security Number 217-55-3763 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) Yrs. 4 Months 25 Days 25 | 8. Date of Birth (Month, Day, Year) 6-17-1999 | | 9. Birthplace (State or Foreign Country) CHEVERLY, MD | | | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County PRINCE GEORGES | 10c. City, Town or Location RIVERDALE | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number 6831-A RIVERDALE RD., #201 | | | 10f. Zip Code 20737 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A | | 16b. Kind of Business/Industry N/A | | | | |
| | 17. Father's Name (First, Middle, Last) ORLANDO ROYSTER | | | | 18. Mother's Name (First, Middle, Maiden Surname) LASHANTRA MAYHEW | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) LASHANTRA MAYHEW - MOTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8429 HAMLIN ST., #103 LANHAM, MARYLAND 20706 | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. OLIVET CEMETERY | | 20c. Location - City or Town, State 17-1999 WASHINGTON, DC | | | | |
| | 21. Signature of Funeral Service Licensee <i>B.C. Taylor</i> | | 22. Name and Address of Facility TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH. DC 20001 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PNEUMONIA | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier <i>Theodore M. King</i> | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) November 12, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 15 1999 | | 32. Registrar's Signature <i>B. Spence</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

March 1, 1900

Page 1 of 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36149

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

State Registrar

Physician /Medical Examiner

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|--|--|---|
| 1. Decedent's Name (First, Middle, Last) Harlan Delno Snow | | 2. Date of Death Month November Day 04 Year 1999 | | 3. Time of Death 05:46 AM. | |
| 4a. Facility Name (If not institution, give street and number) 410 Ridge Road | | | 4b. City, Town, or Location of Death Rising Sun | | 4c. County of Death Cecil |
| 5. Social Security Number 202-56-5311 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 33 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Jan. 3 1966 |
| 9. Birthplace (State or Foreign Country) PA | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | 10b. County Cecil | 10c. City, Town or Location Rising Sun | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 410 Ridge Road | | 10f. Zip Code 21911 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) extrusion operator | | 16b. Kind of Business/Industry manufacturing | | | |
| 17. Father's Name (First, Middle, Last) Santo Perez | | | 18. Mother's Name (First, Middle, Maiden Surname) Barbara Johnson | | |
| 19a. Informant's Name/Relationship (Type, Print) Sheila McColl | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Ridge Road, Rising Sun, MD 21911 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oxford Cemetery | | 20c. Location - City or Town, State 11/9/99 Oxford, PA | |
| 21. Signature of Funeral Service Licensee Edward L. Collins Jr. | | | 22. Name and Address of Facility Collins Funeral Home, 86 Pine St., Oxford, PA | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIOMEGALY a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier Theodore M. King | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) November 4, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore M. King 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 08 1999 | | 32. Registrar's Signature B. Sparks | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36150

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Florence G. Scalessa | | | | 2. Date of Death Month Oct Day 30 Year 1999 | | 3. Time of Death 8:20pm | |
| 4a. Facility Name (If not institution, give street and number) Carriage Hill - Bethesda | | | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery | |
| 5. Social Security Number 577-07-7667 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) July 30 1916 | |
| 9. Birthplace (State or Foreign Country) Washington, DC | | | | | | | |
| 10e. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Bethesda | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 5215 Cedar Lane | | | | 10f. Zip Code 20814 | | 10g. Citizen of What Country? U.S.A | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Housewife | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry Own home | |
| 17. Father's Name (First, Middle, Last) Chelso Giovannoni | | | | 18. Mother's Name (First, Middle, Maiden Surname) Nellie Nawl | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary Ellen Glynn (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10236 Lawyers Rd. Vienna, VA. 22181 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery | | Date 11/3/99 | | 20c. Location - City or Town, State Brentwood, MD | |
| 21. Signature of Funeral Service Licensee Thomas E. Lombardi | | | | 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. Washington, D.C. 20016 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary Artery Disease Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Hypertension Peripheral vascular disease | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier Marc Shepard | | | | 29c. License number DZ6382 | | 29d. Date signed (Month, Day, Year) 11/4/99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Marc Shepard MD 4700 Berwyn House Rd. #105 College Park, Md. 20740 | | | | | | | |
| 31. Date filed (Month, Day, Year) Nov 03 1999 | | | | 32. Registrar's Signature [Signature] | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36151

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn May Spaulding

2. Date of Death

Month Day Year
October 30, 1999

3. Time of Death

5:30 am

4a. Facility Name (If not institution, give street and number)

Solomons Nursing Center

4b. City, Town, or Location of Death

Solomons

4c. County of Death

Calvert

Funeral
Director

5. Social Security Number

578-20-7189

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 7, 1912

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Solomons

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13325 Dowell Road

10f. Zip Code

20688

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Carroll Money

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Emma Dean

19a. Informant's Name/Relationship (Type, Print)

Pauline E. Butler - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22 Timberidge, Sanford, Maine 04073

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Evergreen Cemetery

Date

11/01/99

20c. Location - City or Town, State

Bladensburg, Maryland

21. Signature of Funeral Service Licensee

Cen Lynn Dashi - Brady

22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David J. Tardio MD

29c. License number

047610

29d. Date signed (Month, Day, Year)

November 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David J. Tardio, M.D., 14090 Solomons Island Road South, Suite 2500, Solomons, MD 20688

31. Date filed (Month, Day, Year)

NOV 05 1999

32. Registrar's Signature

A. Smith

State
Registrar

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10

11



11

11

11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36152

| | | | | | | | | | | |
|--|---|--------------------------------|---|---|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Matrena A. Taidakova | | | | 2. Date of Death Month Day Year NOVEMBER 02, 1999 | | | | 3. Time of Death 1230 | |
| | 4a. Facility Name (If not institution, give street and number) 4800 BERWYN HOUSE ROAD #518 | | | | 4b. City, Town, or Location of Death COLLEGE PARK | | | | 4c. County of Death PRINCE GEORGES | |
| Funeral Director | 5. Social Security Number N/A | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (in yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 3, 1914 | | 9. Birthplace (State or Foreign Country) Russia | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location College Park | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number 4800 Berwyn House Road, #518 | | | | 10f. Zip Code 20740 | | | | 10g. Citizen of What Country? Russia | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | | | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Factory Worker | | | | 16b. Kind of Business/Industry Government | | |
| 17. Father's Name (First, Middle, Last) Arkhip F. Kharin | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Irina K. Gabova | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Nikolai N. Gorkavyyi - Son-In-Law | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4800 Berwyn House Rd., #518, College Park, MD 20740 | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland National Cemetery | | Date 11/05/99 | | 20c. Location - City or Town, State Laurel, Maryland | | |
| 21. Signature of Funeral Service Licensee Ceri Lynn Gasch-Grady | | | | 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ARTEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier MARIO F. GOLIE JR MD | | | | 29c. License number D33954 | | | | 29d. Date signed (Month, Day, Year) NOVEMBER 03, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE CHEVERLY MARYLAND 20785 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 05 1999 | | | | 32. Registrar's Signature A. [Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

89 36153

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|---|---|--|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last) Leo Francis Townsend, Sr. | | | | 2. Date of Death Month: Nov. Day: 2 Year: 1999 | | 3. Time of Death 5:07PM | |
| 4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital | | | | 4b. City, Town, or Location of Death Clinton | | 4c. County of Death Prince George's | |
| 5. Social Security Number 579-38-0192 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 68 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Dec. 6, 1930 | 9. Birthplace (State or Foreign Country) Wash., D.C. |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Forestville | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 2541 Oak Glen Way | | | | 10f. Zip Code 20747 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic | | 16b. Kind of Business/Industry Government | |
| 17. Father's Name (First, Middle, Last) Silas Townsend | | | | 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Moore | | | |
| 19a. Informant's Name/Relationship (Type, Print) Dorothy Butler - Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2541 Oak Glen Way, Forestville, MD 20747 | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lee's Crematory | | Date 11-10-99 | | 20c. Location - City or Town, State Clinton, MD | |
| 21. Signature of Funeral Service Licensee John T. Stewart, III | | | | 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 | | | |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. DILATED CARDIOMYOPATHY Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION RENAL FAILURE | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Chick MD | | 29c. License number D53885 | | 29d. Date signed (Month, Day, Year) 11/4/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VENKAT. S. RAMANAN 7501 SURREATS ROAD #307 CLINTON MD 20735 | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 05 1999 | | 32. Registrar's Signature B. Duke | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

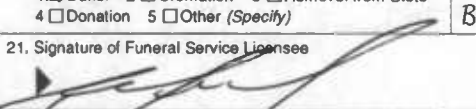
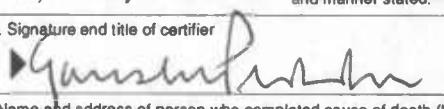
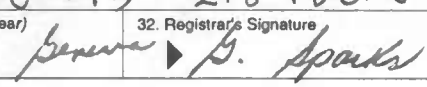
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36154

| | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|--|--|---|--|--|---|----|------------------|----------------------------------|--|----|--|----------------------------------|----|--|----------------------------------|----|--|----------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MIRIAM H. WATSON | | | | 2. Date of Death Month NOV Day 15 Year 1999 | | 3. Time of Death 6:46 AM | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) SA FALLSTON GEN HOSPITAL | | | | 4b. City, Town, or Location of Death FALLSTON | | 4c. County of Death HARFORD | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 219-03-2221 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 89 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 15, 1910 | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10. State Maryland | | 10b. County Cecil | | 10c. City, Town or Location Chesapeake City | | | | | | | | | | | | | | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 611 Biddle Street | | 10f. Zip Code 21915 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bank Clerk | | 16b. Kind of Business/Industry Retail Banking | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Clarence Harrington | | | | 18. Mother's Name (First, Middle, Maiden Surname) May Bungard | | | | | | | | | | | | | | | | | |
| 19e. Informant's Name/Relationship (Type, Print) Sandra F. Tracy/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2506 Rocks Rd. Forest Hill, MD 21050 | | | | | | | | | | | | | | | | | |
| 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Bethel Cemetery | | 20c. Location - City or Town, State Chesapeake City, MD | | 20d. Date 11-5-99 | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility R. T. Foard Funeral Home, P. A. 318 George St. Chesapeake City, MD 21915 | | | | | | | | | | | | | | | | | |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>A S C V D</td> <td>Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | A S C V D | Due to (or as a consequence of): | Approximate Interval Between Onset and Death | b. | | Due to (or as a consequence of): | c. | | Due to (or as a consequence of): | d. | | Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | A S C V D | Due to (or as a consequence of): | Approximate Interval Between Onset and Death | | | | | | | | | | | | | | | | | |
| | b. | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | |
| | c. | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | |
| | d. | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier  M.E. | | | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) NOV 11 1999 | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. PLASHU MD 218 FALLSTON AVE BELAIR MD 21014 | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 03 1999 | | 32. Registrar's Signature  B. Sparks | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36155

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elwood Larry Wickens

2. Date of Death

Month Day Year
NOVEMBER 4, 1999

3. Time of Death

1:55 AM

4a. Facility Name (If not institution, give street and number)

CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death

LAPLATA

4c. County of Death

CHARLES

Funeral
Director

5. Social Security Number

224-30-8153

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
September 29, 1931

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Indian Head

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

22 Potomac Avenue

10f. Zip Code

20640

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

3

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

United States Government

17. Father's Name (First, Middle, Last)

Emery Wickens

18. Mother's Name (First, Middle, Maiden Sumame)

Effie Jones

19a. Informant's Name/Relationship (Type, Print)

Jacqueline Wickens/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22 Potomac Avenue, Indian Head, Maryland 20640

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Funeral Service

Date

November 5, 1999

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Williams Funeral Home, P.A.

MO0668

4270 Hawthorne Road, Indian Head, Maryland 20640

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Acute Respiratory Failure

Due to (or as a consequence of):

Pulmonary Fibrosis

Due to (or as a consequence of):

Acute Pneumonitis

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Interstitial Lung Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

M.D.

29c. License number

D37174

29d. Date signed (Month, Day, Year)

11/3/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SONG C. CHON M.D. CENNA MEDICAL CENTER 7C POST OFFICE ROAD WALDORF MD. 20602

31. Date filed (Month, Day, Year)

NOV 08 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

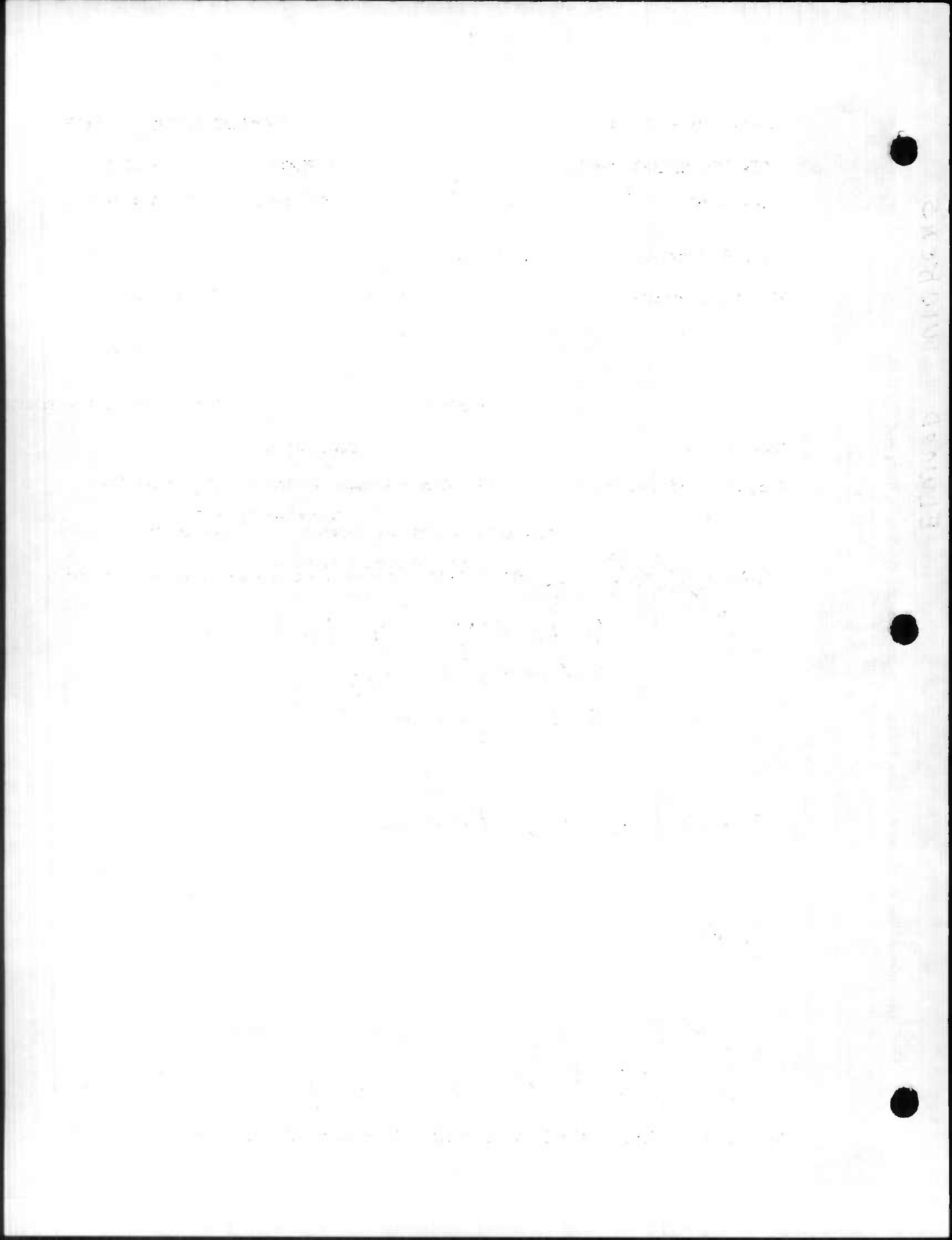
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ELWOOD WICKENS



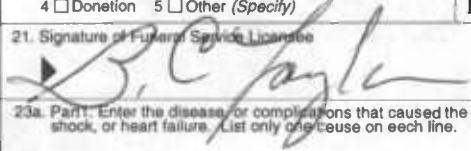
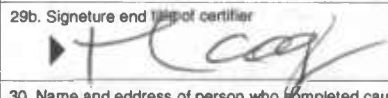

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36156

| | | | | | | | | | |
|---|---|---|--|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DOROTHY FORTUNA PARKER-WILLIAMS | | | | 2. Date of Death Month Day Year OCTOBER 30, 1999 | | 3. Time of Death 6:00pm | | |
| | 4a. Facility Name (If not institution, give street and number) MILLENNIUM HEALTH & REHAB. CTR OF NW BALTIMORE | | | | 4b. City, Town, or Location of Death | | 4c. County of Death | | |
| Funeral Director | 5. Social Security Number 579-78-7970 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 42 Yrs. | | 8. Date of Birth (Month, Day, Year) 4-11-1957 | | |
| | 9. Birthplace (State or Foreign Country) TEXAS | | 10a. State VA | | 10b. County FAIRFAX | | 10c. City, Town or Location RESTON | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 2180 CARTWRIGHT PLACE | | 10f. Zip Code 20194 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | College (1-4 or 5+) 2 | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COMPUTER GRAPHICS TECH | | 16b. Kind of Business/Industry N/A | | | |
| 17. Father's Name (First, Middle, Last) HENRY EDWARD PARKER, SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname) HENRIETTA VIVIAN FORTUNE | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) JELANDA P. WINSTON - DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1603 BECONTREE LANE, #2B RESTON, VA 20190 | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) RIVERDALE PARK CREM. 5-99 | | Date 11- | | 20c. Location - City or Town, State RIVERDALE, MD | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH. DC | | | | | |
| 23a. Part I: Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. END STAGE AUTO IMMUNE DEFICIENCY DISORDER Due to (or as a consequence of): b. CACHEXIA Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | 24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and Title of certifier  | | 29c. License number D0024100 | | 29d. Date signed (Month, Day, Year) November 4, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MADURAL PRABHAKAR, M.D. - 2115 OLD OREMS RD., BALTIMORE, MD 21220 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 05 1999 | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36157

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

IRIS MAE WOODFOLK

2. Date of Death

Month Day Year
NOVEMBER 2, 1999

3. Time of Death

10:30am

4a. Facility Name (If not institution, give street and number)

11628 STEWART LANE #104

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

578-58-5893

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 18, 1943

9. Birthplace (State or Foreign Country)

WASHINGTON DC

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

11628 STEWART LANE #104

10f. Zip Code

20904

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

XX Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NURSE

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

ANTHONY WOODFOLK

18. Mother's Name (First, Middle, Maiden Surname)

LOUISE HARRIS

19a. Informant's Name/Relationship (Type, Print)

DORIS COLE / SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13214 STRAVINSKY TERR. SILVER SPRING, MD 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GEORGE WASHINGTON CEM. 11-8-99 ADELPHI, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOME
11315 LOCKWOOD DRIVE, SILVER SPRING, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. acute myocardial infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. diabetes mellitus

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic renal failure

heart carcinoma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

29c. License number

D20400

29d. Date signed (Month, Day, Year)

11/3/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark S. Rosen, MD

Silver Spring, MD

3941 FERRARA DR
MD 20906

31. Date filed (Month, Day, Year)

NOV 05 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36158

| | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--------------------------------|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Harvey S. White | | | | | 2. Date of Death Month Day Year November 3, 1999 | | | 3. Time of Death 12:05 pm | |
| | 4a. Facility Name (If not institution, give street and number) Sears Manor Assisted Living Center | | | | | 4b. City, Town, or Location of Death Annapolis | | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 579-09-0566 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) March 5, 1918 | | 9. Birthplace (State or Foreign Country) Pennsylvania | |
| | Usual Residence of Decedent | | | | | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Hyattsville |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 6111 39th Place | | 10f. Zip Code 20782 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer | | 16b. Kind of Business/Industry C & P Telephone | | | | | |
| | 17. Father's Name (First, Middle, Last) Wilmer White | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Bertha Alfauter | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Aradina M. White - Wife | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6111 39th Place, Hyattsville, Maryland 20782 | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | 20c. Date 11/06/99 | | 20d. Location - City or Town, State Suitland, Maryland | | | |
| Physician /Medical Examiner | 21. Signatures of Funeral Service Licensees Ceri Lynn Masch-Grady | | | | | 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>BRISPIRATORY FAILURE</u> Due to (or as a consequence of): b. <u>DEBRIDED</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 24 hrs 59 hrs | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ASSISTED LIVING | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| State Registrar | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier John Shauer | | 29c. License number 027838 | | 29d. Date signed (Month, Day, Year) November 5, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN SHAUERS 518 CAMP NIZARD ROAD, LIAITHICUN, MD 21090 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) NOV 05 1999 | | 32. Registrar's Signature B. Shauer | | | | | | | |

ORIGINAL

1950

1951

1952 2 0 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36159

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lillian E. Yech

2. Date of Death
Month Day Year
November 2, 19993. Time of Death
9:30 pm

4a. Facility Name (If not institution, give street and number)

Genesis Woodside Center

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-10-3847

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Nov. 29, 1915

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

College Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4617 Fordham Road

10f. Zip Code

20740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Harry G. Sims

18. Mother's Name (First, Middle, Maiden Surname)

Amelia Webber

19a. Informant's Name/Relationship (Type, Print)

Charles Yech - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4617 Fordham Road, College Park, Maryland 20740

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

11/03/99

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Carli J. Masch - Masch

22. Name and Address of Facility

Gasch's Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Aspiration pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

cachexia

chronic obstructive lung disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

1 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Amendira

29c. License number

D38262

29d. Date signed (Month, Day, Year)

November 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr A. Mendhiratta 2401 Research BLVD Suite 340 Rockville MD 20852

31. Date filed (Month, Day, Year)

NOV 05 1999

32. Registrar's Signature

A. Mendhiratta

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMENDED #23a, PER MD, G777, 11/18/99 DH

Reg. No. 99 36160

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Isaac R. Armstrong

2. Date of Death

Month Day Year
NOVEMBER 05, 1999

3. Time of Death

11:10

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

245-12-2929

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 31, 1921

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State
Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2710 Allendale Rd.

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1 year

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bus Driver

16b. Kind of Business/Industry

MTA

17. Father's Name (First, Middle, Last)

Albert Armstrong

18. Mother's Name (First, Middle, Maiden Surname)

Dona Riddick

19a. Informant's Name/Relationship (Type, Print)

Dorothy Fordbey sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

208 N. Fulton Ave. Baltimore MD.

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forrest Veterans

Date

Nov. 10

20c. Location - City or Town, State

Owings Mills, Md.

21. Signature of Funeral Service Licensee

Herbert E. Nutter

22. Name and Address of Facility

Nutter Funeral Homes, Inc.
2501 Gwynns Falls Pkwy Baltimore, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Aspiration

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

25 minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

{

b.

LUNG CARCINOMA

Due to (or as a consequence of):

c.

COPD

Due to (or as a consequence of):

d.

MI

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lung Carcinoma

COPD

MI

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Pending Investigation☐ Accident☐ Suicide☐ Homicide☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

REG 030

29d. Date signed (Month, Day, Year)

November 05, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHELE D. MENNETTE

SINAI HOSPITAL

2401 W. BELVEDERE

BALTIMORE MD 21215

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

[Signature]

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Patient known as: Armstrong, Isaac
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

00100 00

Handwritten signature

00100 00

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36161

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edith Mary Ambrose | | | | 2. Date of Death Month Day Year NOV 16, 1999 | | 3. Time of Death 9:22am | |
| | 4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | 4c. County of Death AA COUNTY | |
| Funeral Director | 5. Social Security Number 218-09-9923 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) January 15 1917 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Crownsville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 862 Redwood Trail | | 10f. Zip Code 21032 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Household | | | |
| | 17. Father's Name (First, Middle, Last) Frederick W.A. Grote | | | | 18. Mother's Name (First, Middle, Maiden Surname) Anna M. Sink | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Mary Parmer | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 862 Redwood Trail, Crownsville, MD 21032 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Cemetery | | 20c. Date Nov. 20 | | 20d. Location - City or Town, State Glen Burnie, Maryland | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee <i>Shirley Halliday</i> | | | | 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Gastrointestinal bleeding</i> Due to (or as a consequence of): b. <i>Chronic renal failure</i> Due to (or as a consequence of): c. <i>Peripheral vascular disease</i> Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 12 hours many years many years | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier <i>Binika Ashar, M.D.</i> | | 29c. License number D0053777 | | 29d. Date signed (Month, Day, Year) November 16, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Binika Ashar M.D.; 1600 Crain Hwy. SW Suite 406; Glen Burnie MD 21061</i> | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 18 1999 | | 32. Registrar's Signature <i>Anna B. Spaulding</i> | | | | | |

ORIGINAL

10150 88

Handwritten signature

NOV 18 1952

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36162

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CATHERINE ASHBURN | | | | 2. Date of Death Month Day Year NOVEMBER 16th 1999 | | 3. Time of Death 1:40 p.m. | |
| | 4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death n/a | |
| Funeral Director | 5. Social Security Number 218-10-6750 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) March 19, 1915 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 5105 Patrick Henry Drive | | 10f. Zip Code 21225 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Household | | | |
| | 17. Father's Name (First, Middle, Last) Jacob Goldberg | | | | 18. Mother's Name (First, Middle, Maiden Surname) Hanna L. Schuminisky | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Diana Ashburn - Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Dunlap Court, Pasadena, MD 21122 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | Date Nov. 18 | | 20c. Location - City or Town, State Baltimore, Maryland | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmias Due to (or as a consequence of): b. MYOCARDIAL INFARCTION Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death 2 days 3 days |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier  m.d. | | 29c. License number P13472 | | 29d. Date signed (Month, Day, Year) NOVEMBER 16th 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. SANDEEP GAUTAM Harbor Hospital Center 3001 So Hanover St Baltimore, MD 21225 | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year) NOV 18 1999 | | 32. Registrar's Signature  | | | | | |
| | State Registrar | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36163

AMENDED ITEM 106 PER FH G777 11/18/99 AH

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

James Brightful

2. Date of Death

Month Day Year

11 16 99

3. Time of Death

7:00 P.M.

4a. Facility Name (If not institution, give street and number)

Frederick Villa

4b. City, Town, or Location of Death

Catonville

4c. County of Death

Baltimore

5. Social Security Number

29-07-3159

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 22, 1919

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

222 Stonecraft Rd. Apt. F

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Social Security Administration

17. Father's Name (First, Middle, Last)

Oden Brightful

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice Dunson

19a. Informant's Name/Relationship (Type, Print)

Mary Brightful - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

222 Stonecraft Rd. Apt. F Baltimore Maryland 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Vet. Cem.

Date

7/22

20c. Location - City or Town/State

Baltimore Maryland

21. Signature of Funeral Service Licensee

Kevin Parker

22. Name and Address of Facility

Kevin A. Parker Funeral Home
3512 Frederick Ave. Baltimore MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis
Due to (or as a consequence of):b. Pneumonia
Due to (or as a consequence of):c. Respiratory failure
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Wk

Wk

Wk

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIC
Cardiac arrhythmia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. Turakhia

29c. License number

D36942

29d. Date signed (Month, Day, Year)

NOV 17, 99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

B. TURAKHIA, MD 1009, Frederick Rd Baltimore, MD 21228

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

B. Turakhia

State
Registrar

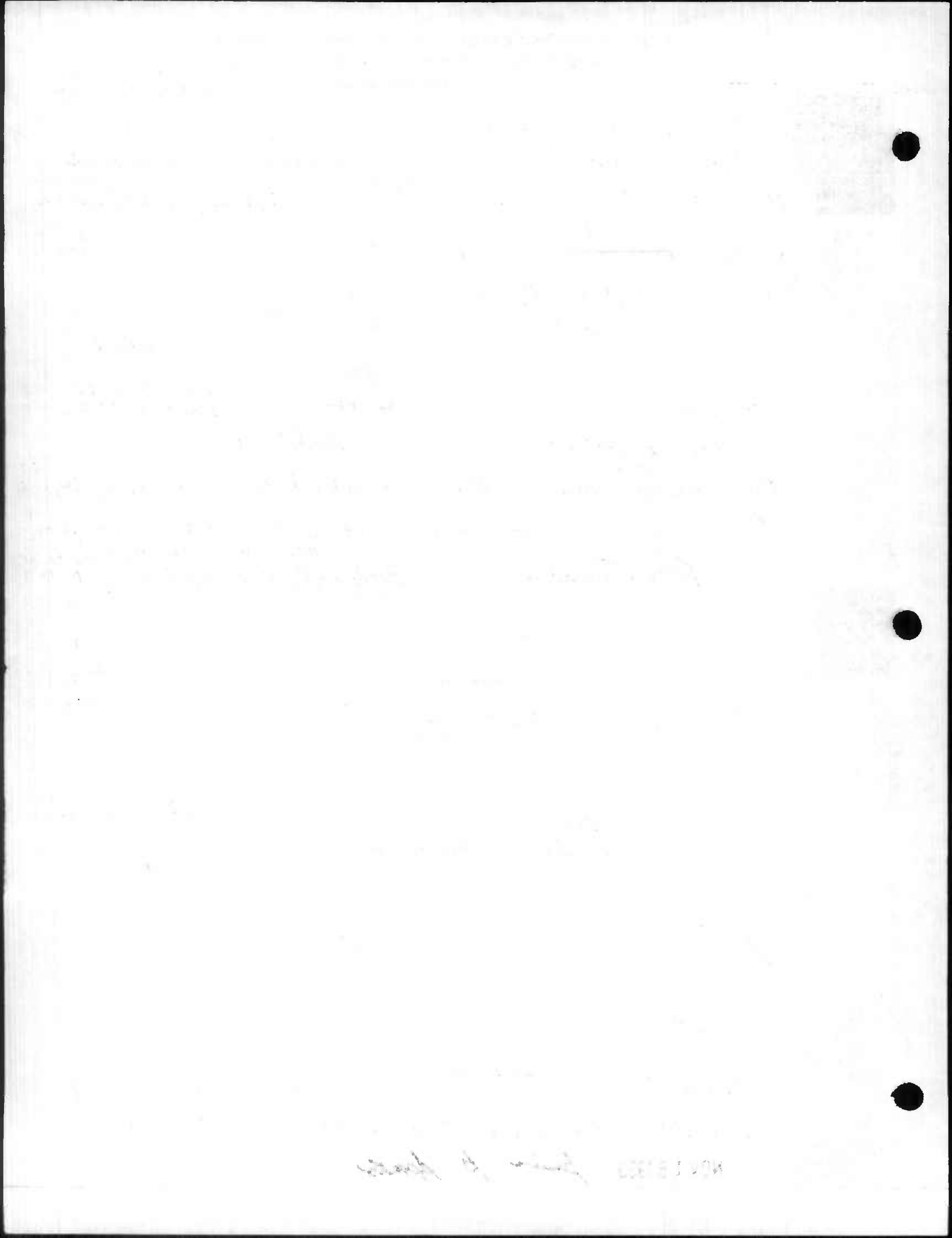
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

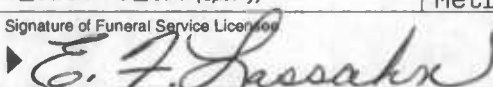
Reg. No.

99 36164

AMENDED #23aPER MD,G777 11/18/99 DH

Physician
/Medical
Examiner

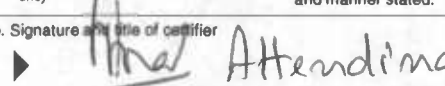
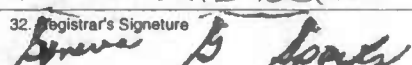
Funeral
Director

| | | | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Betty Jean Brown | | | | | | 2. Date of Death Month October Day 30 Year 1999 | | 3. Time of Death 3:05Am | |
| 4a. Facility Name (If not institution, give street and number) Fallston General Hospital | | | | 4b. City, Town, or Location of Death Fallston | | 4c. County of Death Harford | | | |
| 5. Social Security Number 220-24-1038 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Feb.2,1928 | | 9. Birthplace (State or Foreign Country) Baltimore,MD. | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Kingsville | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 12301 Stoney Batter Road | | | | 10f. Zip Code 21087 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 yrs. College (1-4or 5+) n/a | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | | 16b. Kind of Business/Industry Home | | |
| 17. Father's Name (First, Middle, Last) Rosco Jones | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Agnes Hamilton | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mr.Emory Brown (Husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12301 Stoney Batter Rd. Kingsville,MD.21087 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | Date 11/2/99 | | 20c. Location - City or Town, State Baltimore,MD. | |
| 21. Signature of Funeral Service Licensor  | | | | 22. Name and Address of Facility E.F.Lassahn Funeral Home 11750 Belair Road Kingsville,MD.21087 | | | | | |

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|---|--|---------------------------------------|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death) Respiratory failure | | | | | | 1 week | |
| Due to (or as a consequence of): ASPIRATION PNEUMONIA | | | | | | 1 wk | |
| Due to (or as a consequence of): SEPSIS | | | | | | 1 wk | |
| Due to (or as a consequence of): | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PARKINSON Disease, seizure Disorder | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier  Attending | | | | 29c. License number D-16444 | | 29d. Date signed (Month, Day, Year) October 30th 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIJAY S. NAIR M.D. 2112 Belair Road. Fallston. MD 21047. | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | 32. Registrar's Signature  | | | | | |

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Betty J Brown

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Handwritten signature

NOV 1 1950

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36165

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

OILIST

OTIS

BRYANT

2. Date of Death

Month

Day

Year

Nov.

16

1999

3. Time of Death

9:05 AM

4a. Facility Name (If not institution, give street and number)

1522 MCKEAN AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

220 64 3795

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

44

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

08/11/1955

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1522 MCKEAN AVENUE

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

CHARLIE BRYANT

18. Mother's Name (First, Middle, Maiden Surname)

ETHEL WILKINS

19a. Informant's Name/Relationship (Type, Print)

LOIS DAVIDSON/SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3710 ARCADIA AVENUE BALTIMORE, MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MT. CALVARY CEMETERY

Date

11/20/99 BALTO., MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

JAMES A. MORTON & SONS F.H., INC

1701 LAURENS ST. BALTO., MD, 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

ADVANCED AIDS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒

Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐

Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Vasanthakumar MD

29c. License number

D42510

29d. Date signed (Month, Day, Year)

Nov. 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. VASANTHA KUMAR MD

821 N. EUTAW ST, 407, MD 21201

State
Registrar

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

Barbara B. Sparks

ORIGINAL

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36166

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MILTON FREDERICK BETTS

2. Date of Death

November 12, 1999

3. Time of Death

1:42 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

r/12

5. Social Security Number

216-78-5715

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

41 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 26, 1958

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

2527 OSWEGO AVE

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

Never Married ☒ Married ☐3 Widowed ☐ 4 Divorced ☐

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes ☐ 2 No ☒

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes ☐ 2 No ☒ Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12th grade

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Construction Worker

16b. Kind of Business/Industry

Castaway's Construction Co.

17. Father's Name (First, Middle, Last)

JAMES BETTS

18. Mother's Name (First, Middle, Maiden Surname)

RUTH TOWNES

19a. Informant's Name/Relationship (Type, Print)

FRANCES TOWNES / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2527 OSWEGO AVE BALTIMORE, MD 21215

20a. Method of Disposition

Burial ☒ 2 Cremation ☐ 3 Removal from State ☐4 Donation ☐ 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

11-19-99

20c. Location - City or Town, State

BALTIMORE, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CHATHAM - Home E.H.

5240 REISTERSTOWN ROAD

BALTIMORE, MD 21215

23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. SEPSIS

Due to (or as a consequence of):

b. PERITONITIS

Due to (or as a consequence of):

c. (ESRD) End Stage Renal Disease.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure, Hypertension, Hepatitis C Virus, Gastroparesis, Seizures, Anemia, Recent Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death?

1 Yes ☐ 2 No ☒ 3 Probably ☐ 4 Unknown ☐

24a. Was an autopsy performed?

1 Yes ☐ 2 No ☒

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes ☐ 2 No ☐

25. Was case referred to medical examiner?

1 Yes ☐ 2 No ☒

26. Place of Death (Check only one)

Hospital: 1 Inpatient ☒ 2 ER/Outpatient ☐ 3 DOA ☐ Other: 4 Nursing Home ☐ 5 Residence ☐ 6 Other (Specify)

27. Manner of Death

1 Natural ☒ 5 Pending investigation ☐2 Accident ☐ 6 Could not be determined ☐3 Suicide ☐ 4 Homicide ☐

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes ☐ 2 No ☒

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

JOHN ADAMS

29c. License number

89344

29d. Date signed (Month, Day, Year)

11/12/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOHN ADAMS C/O MARYLAND GENERAL HOSPITAL

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

P. Sparks

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36167

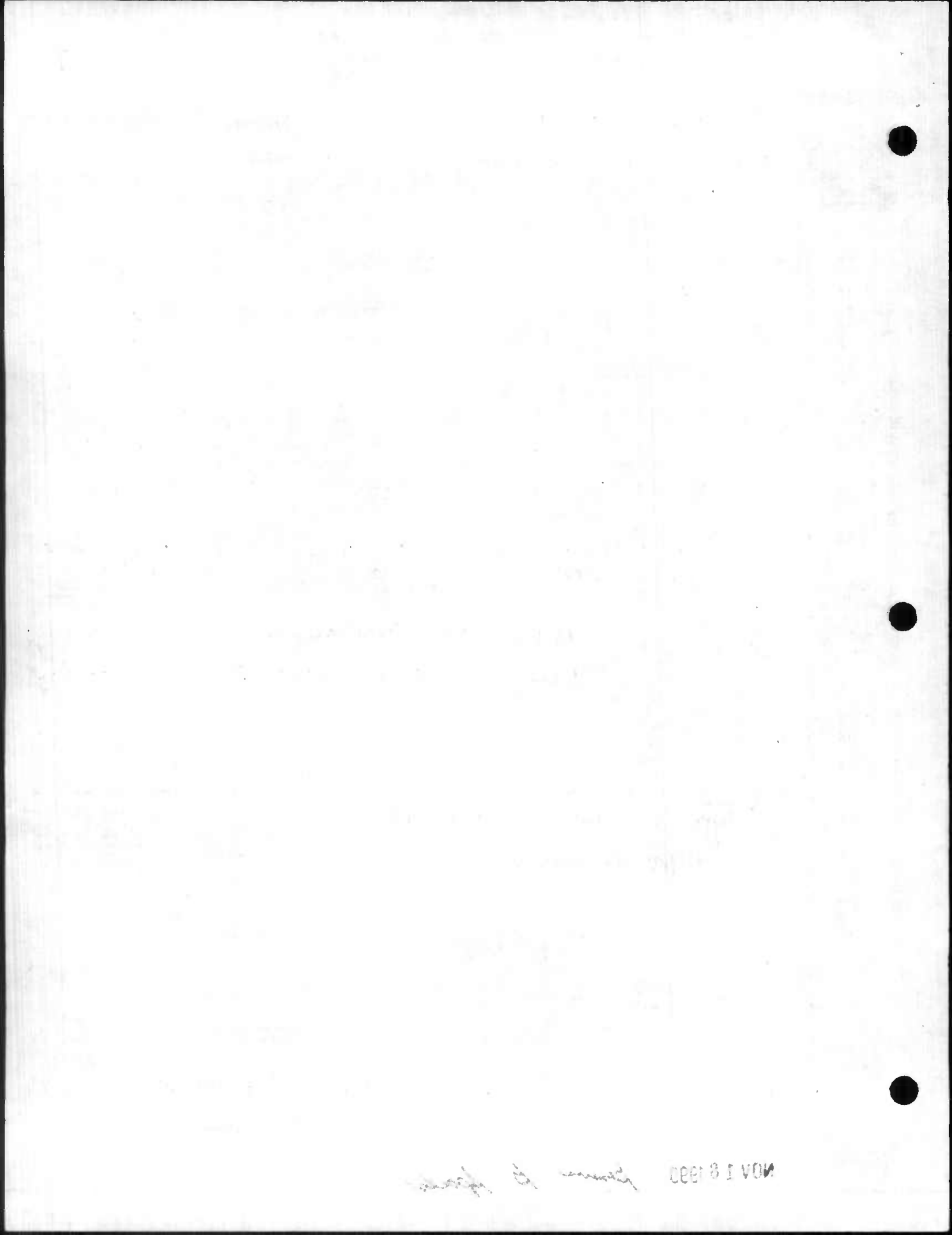
Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) TYRONE BROOKS | | | | 2. Date of Death Month Day Year NOVEMBER 11 1999 | | 3. Time of Death 9:10 PM | |
| | 4a. Facility Name (If not institution, give street and number) HANOVER HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 220-66-1401 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 43 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) AUG 20, 1956 | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. State MD | | 10b. County | | 10f. Zip Code 21225 | | 10g. Citizen of What Country? USA | | |
| 10e. Street and Number 603 Bridgeview Rd Apt A | | | | 10f. Zip Code 21225 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Insulator | | 16b. Kind of Business/Industry Construction | | |
| 17. Father's Name (First, Middle, Last) Lionet Jones | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Loretta Turner | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Aletha Brooks/spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 Bridgeview Rd Apt E Baltimore, MD 21225 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | | |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) Aspiration PNEUMONIA | | | | | | | | 20 days |
| Due to (or as a consequence of): Cerebrovascular Accident | | | | | | | | 20 days |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. TYPE 1 DIABETES MELLITUS HYPERTENSION | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Anuraadha Boddeti MD | | | | 29c. License number AS2441614 A34 | | 29d. Date signed (Month, Day, Year) November 11 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANURADHA BODDETI 3001 S HANOVER ST. | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | 32. Registrar's Signature [Signature] | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36168**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Stewart Huber Carter

2. Date of Death

Month Day Year
NOV 15 1999

3. Time of Death

8:15 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Augsburg Lutheran Home

4b. City, Town, or Location of Death

Pikesville

4c. County of Death

Baltimore

5. Social Security Number

215-05-9176

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 17, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3819 Southern Cross Drive

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Self-Employed

17. Father's Name (First, Middle, Last)

Thomas Vance Carter

18. Mother's Name (First, Middle, Maiden Surname)

Sadie Huber

19a. Informant's Name/Relationship (Type, Print)

Connie Rebar/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3819 Southern Cross Dr. Baltimore, MD 21207

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory, Inc. 11/16/99

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Thomas Gregor

22. Name and Address of Facility

Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. METASTATIC LIVER CARCINOMA

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

4 WEEKS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Deborah I. Pierce

29c. License number

H45931

29d. Date signed (Month, Day, Year)

November 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah I. Pierce 7220 Park Heights Avenue Baltimore, MD

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

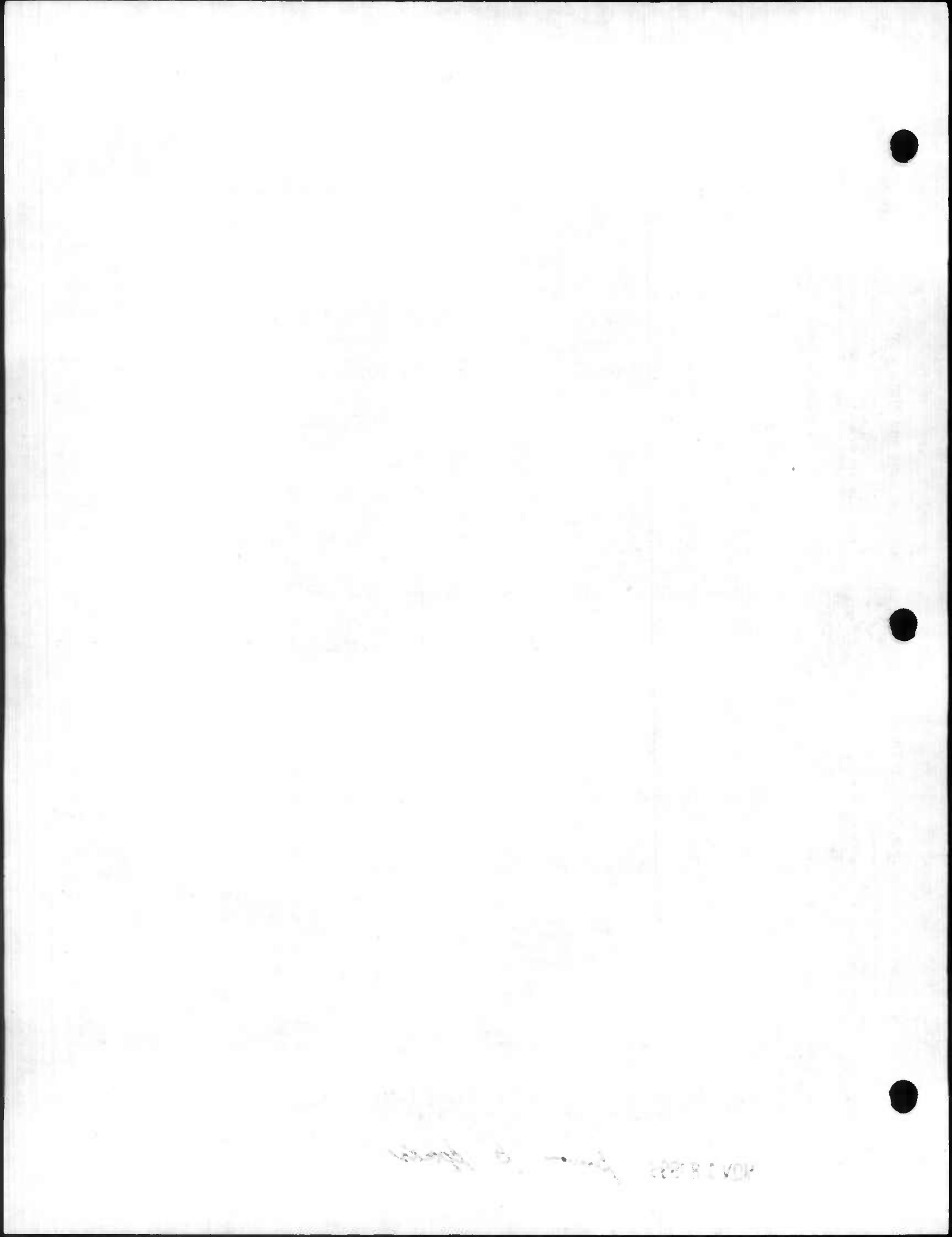
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36169**
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|---|--|--|--|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Thomas Gridley Casey II | | | | 2. Date of Death Month October Day 6 Year 1999 | | | | 3. Time of Death 11:25pm | |
| | 4a. Facility Name (If not institution, give street and number) Memorial Hospital | | | | 4b. City, Town, or Location of Death Cumberland | | | | 4c. County of Death Allegany | |
| Funeral Director | 5. Social Security Number 214-42-5941 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 56 Yrs. | | 8. Date of Birth (Month, Day, Year) 4-14-1943 | | 9. Birthplace (State or Foreign Country) PA | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County Allegany | | 10c. City, Town or Location Mount Savage | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 15525 Station Master Row | | | | 10f. Zip Code 21545 | | | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Environmental Sanitarian | | | | 16b. Kind of Business/Industry Sanitation | | |
| 17. Father's Name (First, Middle, Last) Thomas Gridley Casey | | | | 18. Mother's Name (First, Middle, Maiden Surname) Gretchen Wanner | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Doris E. Warren (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 490 Mt.Savage, MD 21545 | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Anatomic Gift Fnd. | | 20c. Date 10/7/99 | | 20d. Location - City or Town, State Laurel, MD | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Anatomic Gift Foundation 13948 Baltimore Ave. Laurel, MD 20707 | | | | | | |
| 23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death) Acute respiratory</p> <p>Due to (or as a consequence of): Acute GI bleeding</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic Alcoholic Liver disease</p> <p>Due to (or as a consequence of): esophageal Varices</p> </div> <div style="width: 15%;"> <p>Approximate Interval Between Onset and Death 5 dys years years years</p> </div> </div> | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Delirium Tremens | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | | | 29c. License number D40693 | | 29d. Date signed (Month, Day, Year) October 7, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Elian, 921 Seton Drive, Suite F, Cumberland, MD 21502 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

1977

Department of the Interior

Wildlife Division

10

Re: [illegible]

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X

NOV 18 1980

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36170

| | | | | | | | | | | | |
|---|---|---|--|--|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EWAN CHAMBERS | | | | | | 2. Date of Death Month Day Year NOVEMBER 15, 1999 | | 3. Time of Death 9.40pm | | |
| | 4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | | | |
| Funeral Director | 5. Social Security Number 220-46-8495 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | |
| | 8. Date of Birth (Month, Day, Year) December 8, 1915 | | 9. Birthplace (State or Foreign Country) Canada | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 28 Over Ridge Ct. | | 10f. Zip Code 21210 | | 10g. Citizen of What Country? United States | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-45 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) obstetrician | | 16b. Kind of Business/Industry medical | | 17. Father's Name (First, Middle, Last) William John McAree Chambers | | 18. Mother's Name (First, Middle, Maiden Surname) Olive Watson Buchanan | | | |
| 19a. Informant's Name/Relationship (Type, Print) Laurette Chambers/wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Over Ridge Ct. Baltimore, MD 21210 | | | | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory | | 20c. Location - City or Town, State Baltimore, Maryland | |
| 21. Signature of Funeral Service Licensee John D. Mitchell II | | 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ASPIRATION PNEUMONIA | | Approximate Interval Between Onset and Death 1 day | | | |
| 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. COLONIC CANCER - DUKE STAGE C PROSTATE CANCER | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Mamatha R. Sadda M.D. | | | | 29c. License number AT- 2438946 | | 29d. Date signed (Month, Day, Year) November 15 th , 1999. | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAMATHA R. SADDA, UNION MEMORIAL HOSPITAL, 201 E. University pkwy, Baltimore MD - 21218. | | 31. Date filed (Month, Day, Year) NOV 18 1999 | | | | 32. Registrar's Signature [Signature] | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

REC'D: 1 NOV

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36171

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN CHANEY

2. Date of Death

NOV. 14, 1999

3. Time of Death

7:38AM

4a. Facility Name (If not institution, give street and number)

BON SECOUR

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213 30 0779

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

65

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
06/10/1934

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1601 SPRAY CT.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DAYCARE PROVIDER

16b. Kind of Business/Industry

CHILDCARE

17. Father's Name (First, Middle, Last)

ROBERT JONES

18. Mother's Name (First, Middle, Maiden Summa)

ESTELLE COOK

19a. Informant's Name/Relationship (Type, Print)

OLIVER CHANEY/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1601 SPRAY CT. BALTIMORE, MD. 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON VET. CEM

Date

11/19/99

20c. Location - City or Town, State

OWINGS MILL, MD

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

JAMES A. MORTON & SONS F.H., INC
1701 LAURENS ST., BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Lung Carcinoma

Due to (or as a consequence of):

b.

Diabetes

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. D. Dave

29c. License number

P11903

29d. Date signed (Month, Day, Year)

11/16/99

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Mitul Dave M.D. 40 2000 W. Baltimore St. Baltimore, Md 21223

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

James B. Sparks

State
RegistrarEvelyn Chaney
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

mdufz

AH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36172

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Lincoln Julius Dinkins</u> | | | | 2. Date of Death Month <u>November</u> Day <u>10</u> Year <u>1999</u> | | 3. Time of Death <u>2103</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>Union Memorial Hospital</u> | | | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number <u>218-42-4387</u> | | 6. Sex <u>1</u> M <u>2</u> F | | 7. Age (In yrs. last birthday) <u>52</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>8 31 47</u> | |
| | 9. Birthplace (State or Foreign Country) <u>Virginia</u> | | 10a. State <u>Md.</u> | | 10b. County <u>N/A</u> | | 10c. City, Town or Location <u>Baltimore</u> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <u>1</u> Yes <u>2</u> No | | 10e. Street and Number <u>2032 North Calvert St.</u> | | 10f. Zip Code <u>21218</u> | | 10g. Citizen of What Country? <u>USA</u> | |
| | 11. Marital Status <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>Black</u> | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8th</u> College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>UKN</u> | | 16b. Kind of Business/Industry <u>UKN</u> | | 17. Father's Name (First, Middle, Last) <u>Issac Dinkins</u> | |
| | 18. Mother's Name (First, Middle, Maiden Surname) <u>Francis Minor</u> | | 19a. Informant's Name/Relationship (Type, Print) <u>Ella Johnson - Sister</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2032 N. Calvert St. Balto., Md. 21218</u> | | 20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Metro Crematory</u> | | 20c. Date <u>11-18-99</u> | | 20d. Location - City or Town, State <u>Balto., Md.</u> | | 21. Signature of Funeral Service Licensee <u>Jeff Miller</u> | |
| | 22. Name and Address of Facility <u>Jeff Miller P.C. Funeral Home & Services</u> <u>1639 N. Broadway Balto., Md. 21213</u> | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Sepsis</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>Acquired Immune Deficiency Syndrome</u> <u>Endocarditis</u> | | 23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown | | 23c. Approximate Interval Between Onset and Death <u>3 days</u> | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No | | 24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No | | 25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No | | 26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) | |
| | 27. Manner of Death <u>1</u> Natural <u>5</u> Pending Investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? <u>1</u> Yes <u>2</u> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| | 29b. Signature and title of certifier <u>Macaya Dougouh MD</u> | | 29c. License number <u>AT2438946</u> | | 29d. Date signed (Month, Day, Year) <u>11/10/99</u> | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>MACAYA DOUGOUH Union Memorial Hospital 201 East University Pkwy Baltimore MD 21218</u> | |
| State Registrar | 31. Date filed (Month, Day, Year) <u>NOV 18 1999</u> | | 32. Registrar's Signature <u>Benjamin B Sparks</u> | | 33. Date of Death (Month, Day, Year) <u>11/10/99</u> | | 34. Time of Death (Month, Day, Year) <u>2103</u> | |

Baltimore, Maryland 21215-0020

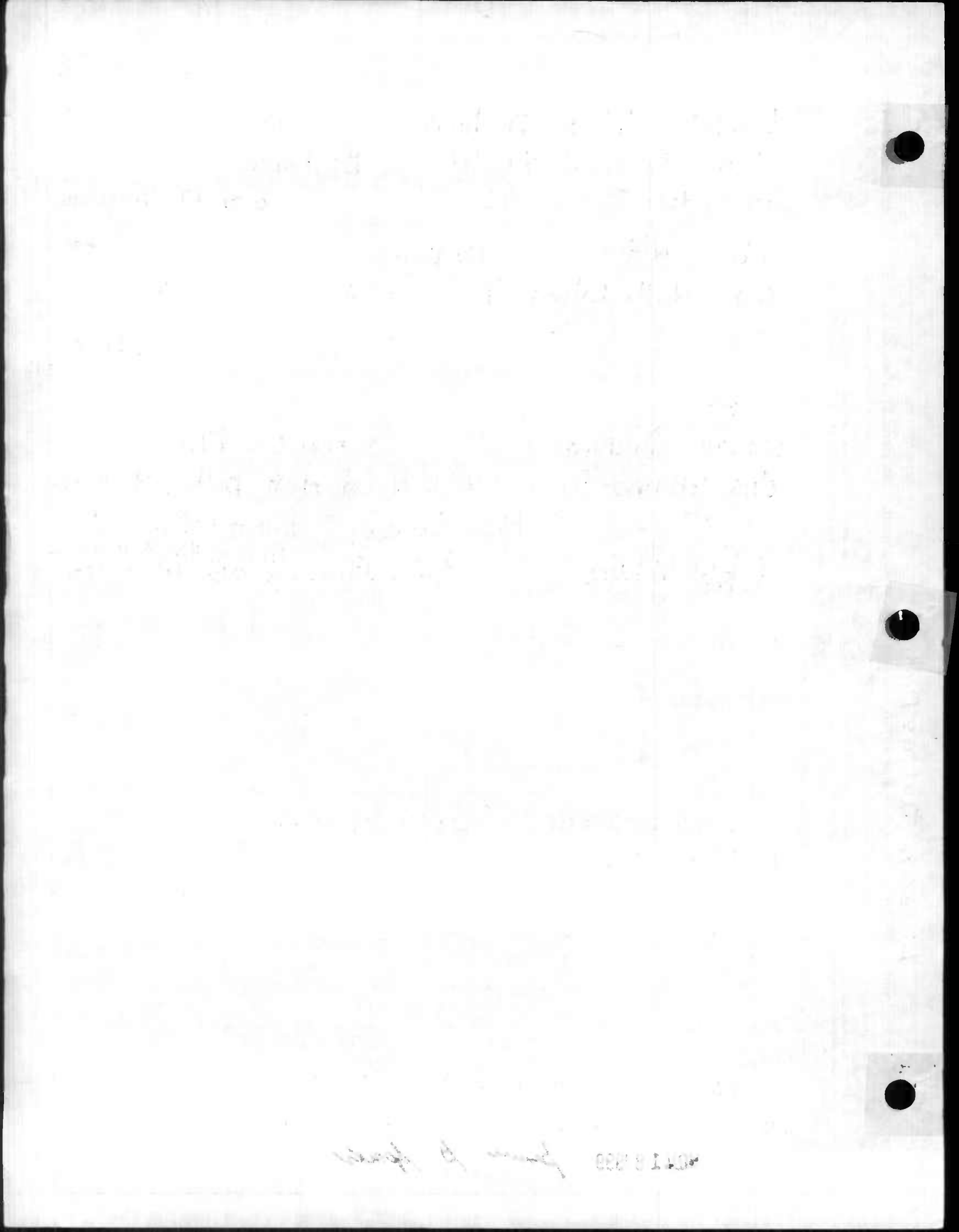
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36173

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

IRENE M. DAVIES

2. Date of Death

Month

Day

Year

11

18

99

3. Time of Death

11:21 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

HONG GREEN

115 E. MELROSE

4b. City, Town, or Location of Death

BAH

4c. County of Death

N/A

5. Social Security Number

220-46-7751

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99

8. Date of Birth

Jan. 28 1900

9. Birthplace (State or Foreign Country)

Canada

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BAHMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

115 E. Melrose Ave.

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

John Aikens MacLeod

18. Mother's Name (First, Middle, Maiden Summa)

Annie McDonald

19a. Informant's Name/Relationship (Type, Print)

Eagles Funeral Home

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Westville, Nova Scotia Canada BOKZAO

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gladstone Cemetery

Date

11-20-99

20c. Location - City or Town, State

Nova Scotia, Canada

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd. Towson, MD. 21204

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Attending

29c. License number

D17118

29d. Date signed (Month, Day, Year)

Nov 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Schwartz M.D. 115 E. Melrose Ave 21212

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

[Signature] B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36174

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

| | | | | | |
|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) ROLAND WILBUR DUNKERLY | | 2. Date of Death Month Day Year NOV 16 1999 | | 3. Time of Death H:50PM | |
| 4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL | | 4b. City, Town, or Location of Death GLEN BURNIE | | 4c. County of Death AA COUNTY | |
| 5. Social Security Number 215-07-7880 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 93 Yrs. | 8. Date of Birth (Month, Day, Year) AUG. 2, 1906 | 9. Birthplace (State or Foreign Country) MARYLAND | |

Funeral
Director

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|
| Usual Residence of Decedent | | 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location GLEN BURNIE | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 701 MARLBORO ROAD | | 10f. Zip Code 21061 | | 10g. Citizen of What Country? U.S.A. | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WELDER | | 16b. Kind of Business/Industry W.R. GRACE COMPANY | | | | | |
| 17. Father's Name (First, Middle, Last) JOHN DUNKERLY | | | | 18. Mother's Name (First, Middle, Maiden Surname) GRACE BRYAN | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ROLAND R. DUNKERLY- SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 MARLBORO ROAD, GLEN BURNIE, MD 21061 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY | | Data 11/19/99 | | 20c. Location - City or Town, State ELKRIDGE, MARYLAND | | | |
| 21. Signature of Funeral Service Licensed | | | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, PA. 1 SECOND AVE., S.W., GLEN BURNIE, MD 21061 | | | | | |

Physician
/Medical
Examiner

| | | | |
|--|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sudden Death Due to (or as a consequence of): b. Congestive Heart Failure Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death minutes 10 years | |
|--|--|---|--|

| | | | |
|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. History of Subdural Hematoma Depression | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |

| | | | | | |
|---|--|---|--|--|--|
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |

| | |
|--|--|
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
|--|--|

| | | | | | |
|---|--|---------------------------------|--|---|--|
| 29b. Signature and title of certifier Neil E. Padgett MD | | 29c. License number D0033296 | | 29d. Date signed (Month, Day, Year) 11/17/99 | |
|---|--|---------------------------------|--|---|--|

| | |
|--|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil Padgett, M.D. 7711 Quarterfield Road, Glen Burnie, MD 21061 | |
|--|--|

| | | | |
|--|--|--|--|
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | 32. Registrar's Signature B. Sparks | |
|--|--|--|--|

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1933 10 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36175

| | | | | | | | | | | |
|---|---|--|---|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Dorothy Dotson | | | | 2. Date of Death Month October Day 13 Year 1999 | | | | 3. Time of Death 10:36 am | |
| | 4e. Facility Name (If not institution, give street and number) Good Samaritan Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 228-38-6682 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 Yrs. | | 8. Date of Birth (Month, Day, Year) Apr. 25 1931 | | 9. Birthplace (State or Foreign Country) Virginia | |
| | 10e. State Maryland | | | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | |
| To Be Completed by Funeral Director | 10e. Street and Number 2014 E. Eager Street | | | | 10f. Zip Code 21205 | | | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) 6th grade | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | | | 16b. Kind of Business/Industry Own Home | |
| | 17. Father's Name (First, Middle, Last) Thomas H. Dotson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marie Dyson | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Harwin Dotson Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 331 S. Ballou Ct Baltimore, Md 21231 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) New Poplar Mount Bapt. Ch. Cem. | | | | 20c. Location - City or Town, State 10/20/99 Notaway, Virginia | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Gray Davis | | | | 22. Name and Address of Facility CHIA TAYAN - Harris P.N. 5240 REISTERSTOWN ROAD Baltimore, Maryland 21211 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. PNEUMONIA Due to (or as a consequence of): b. TEMPORAL ARTERITIS Due to (or as a consequence of): c. DEMENTIA Due to (or as a consequence of): d. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | Approximate Interval Between Onset and Death | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28e. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29c. License number D52228 | | | | 29d. Date signed (Month, Day, Year) 11/16/99 | |
| | 29b. Signature and title of certifier Bhalodiya | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Bhalodiya, Vipolkumar, M.D. 3007 E. Northern Pkwy Baltimore, MD 21214 | | | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year) NOV 18 1999 | | | | 32. Registrar's Signature James B. Sparks | | | | | |
| | State Registrar | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36176

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

ALBERT S. EDWARDS

2. Date of Death

November 4th 1999

3. Time of Death

9:00 PM

4a. Facility Name (If not institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

218-09-0725

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct 30, 1919

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

Millenium Health 2 Fayette Street

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates: unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
unknownCollege (1-4or 5+)
unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Sophie Brown/friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ANOXIC ENCEPHALOPATHY
Due to (or as a consequence of):b. SEPSIS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Hypotension
Due to (or as a consequence of):

d. Renal Failure

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Terance Lamb M.D.

29c. License number

D37203

29d. Date signed (Month, Day, Year)

November 4th 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Terance L. Lamb M.D. Bon Secours Hospital, Baltimore MD.

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

Brenda S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature

NOV 18 1903

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36177

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DORIS RAUNIO FELL

2. Date of Death

November 17, 1999

3. Time of Death

8:03AM

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

016-22-4195

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

August 21, 1928

9. Birthplace (State or Foreign Country)

Connecticut

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2013 Ruxton Road

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Mathmetician

16b. Kind of Business/Industry

University

17. Father's Name (First, Middle, Last)

Waino August Raunio

18. Mother's Name (First, Middle, Maiden Surname)

Anna Honkanen

19a. Informant's Name/Relationship (Type, Print)

Thomas T Fell

Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2013 Ruxton Road Towson, Maryland 21204

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Greenmount Cemetery

Date

11/18/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Bernis Stephen Kenner

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home Inc.

6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

4 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W.A. Riley, MD

29c. License number

025205

29d. Date signed (Month, Day, Year)

November 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley, MD 6701 N. Charles St. Balto. MD 21204

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

*Bernis Stephen Kenner*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ORIGINAL

James O. Smith

James O. Smith

NOV 18 1880

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36178

| | | | | | | | | | | | |
|---|---|--|---|---|---|--------------------------|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Olivia C. Fuhrman | | | | 2. Date of Death Month Day Year November 16, 1999 | | | | 3. Time of Death 1:10 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number) Marriott Brighton Gardens of Pikesville | | | | 4b. City, Town, or Location of Death Pikesville | | | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 217-09-5856 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 20, 1916 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Owings Mills | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 5216 Stone Shop Circle | | | | 10f. Zip Code 21117 | | | | 10g. Citizen of What Country? United States | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) -0- | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) John J. Cronie | | | | 18. Mother's Name (First, Middle, Maiden Surname) Annie Rule | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mr. Paul B. Fuhrman - Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5216 Stone Shop Circle; Owings Mills, Maryland 21117 | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore/Washington Crem. | | 20c. Location - City or Town, State Laurel, Maryland | | 20d. Date 11/17/99 | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death) a. <u>Arteriovascular disease</u> | | | | | | | | | | Years | |
| Due to (or as a consequence of): | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Assisted Living | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred Living | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D 35844 | | | | 29d. Date signed (Month, Day, Year) November 16, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. Roggen 5400 Old Court Road Randallstown MD 21133 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36179

| | | | | | | | | |
|--|--|--|---|--------------------------------------|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Christina Rita French | | | | 2. Date of Death Month Day Year Nov. 17, 1999 | | 3. Time of Death 3:45 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) 505 Granleigh Rd. | | | | 4b. City, Town, or Location of Death Owings Mills | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 213-05-2831 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 23, 1918 | |
| | 9. Birthplace (State or Foreign Country) Baltimore, Md. | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Owings Mills | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 505 Granleigh Road | | 10f. Zip Code 21117 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) +1 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Manager | | 16b. Kind of Business/Industry Cleaners | | | |
| | 17. Father's Name (First, Middle, Last) William French | | | | 18. Mother's Name (First, Middle, Maiden Surname) Carrie Marll | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Catherine Kennedy - niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 Granleigh Rd. Owings Mills, Md. 21117 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cem. Nov. 20, 1999 Baltimore, Md. | | 20c. Location - City or Town, State | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, Md. 21117 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Malignant Melanoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | | | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D33184 | | 29d. Date signed (Month, Day, Year) November 18, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan Kushner 114 Business Center Drive Reisterstown, MD | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 18 1999 | | | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36180**
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|--|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Margaret K. Foley | | | | 2. Date of Death Month November Day 12 , Year 1999 | | 3. Time of Death 11:30 PM | | | |
| | 4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | | |
| Funeral Director | 5. Social Security Number 216-03-4944 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 89 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 9, 1909 | | 9. Birthplace (State or Foreign Country) Canada | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number 3310 Glenmore Avenue | | | 10f. Zip Code 21214 | | 10g. Citizen of What Country? U.S.A. | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Person | | | 16b. Kind of Business/Industry Hutzlers | | | | |
| | 17. Father's Name (First, Middle, Last) Patrick J. Kinsella | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Burns | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Joseph Foley/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104 Morenga Court Fallston, Maryland 21047 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery | | Date 11/16/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic coronary artery disease Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | 29c. License number 121022 | | 29d. Date signed (Month, Day, Year) 11-15-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Kowalski 8114 SANDPICKER CIRCLE STEW M D 21226 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

DHMM 16 Rev 6/95

99 36181

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LEWIS EDISON GLASER | | | | 2. DATE OF DEATH MONTH 11 DAY 11 YEAR 99 | | 3. TIME OF DEATH 9:50 AM | |
| 4. SOCIAL SECURITY NUMBER 218-10-8108 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) November 18, 1919 | |
| 9a. FACILITY NAME (If not Institution, give street and number) 1334 Dennings Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH New Windsor | | 9c. COUNTY OF DEATH Carroll | |
| 10a. STATE MD | | | | 10b. COUNTY Carroll | | 10c. CITY, TOWN OR LOCATION New Windsor | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1334 Dennings Road | | | |
| 10f. ZIP CODE 21776 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Marketing Manager | | 16b. KIND OF BUSINESS/INDUSTRY Utility | | | |
| 17. FATHER'S NAME (First, Middle, Last) Lewis Glaser | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth McFadden | | | |
| 19a. INFORMANT'S NAME (Type/Print) Marie Glaser/Wife | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1334 Dennings RD., New Windsor, MD 21776 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Lawn | | 20c. LOCATION — City or Town, State Hagerstown, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | 22. NAME AND ADDRESS OF FACILITY Grove Funeral Home, P.A. 141 W. Main St. Hancock, MD 21750-0368 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pancreatic Carcinoma Approximate Interval Between Onset and Death 6 mos Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD | | | | 29c. LICENSE NUMBER D38915 | | 29d. DATE SIGNED (Month, Day, Year) 11/11/99 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FREIJ, 295 STONER AVE WESTMINSTER MD 21157 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) NOV 18 1999 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36182

| | | | | | | | | |
|--|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOHN HENRY GRINER, JR. | | | | 2. Date of Death Month <u>11</u> Day <u>15</u> Year <u>99</u> | | 3. Time of Death <u>1:00PM</u> | |
| | 4e. Facility Name (If not institution, give street and number) 3010 ELGIN AVE. | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 219-10-7360 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) 3-3-24 | |
| | 10a. State MD. | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number 3010 ELGIN AVE. | | | | 10f. Zip Code 21216 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>-12-</u> College (1-4or 5+) <u>-0-</u> | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CARPENTER | | 16b. Kind of Business/Industry BETHLEHEM STEEL | | | |
| | 17. Father's Name (First, Middle, Last) JOHN H. GRINER, SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname) JOSEPHINE MAHONEY | | | |
| | 19a. Informant's Name/Relationship (Type, Print) GERALDINE W. GRINER(WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3010 ELGIN AVE. BALTIMORE, MARYLAND 21216 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK | | 20c. Location - City or Town, State BALTIMORE, MARYLAND | | 20d. Date 11-19-99 | |
| | 21. Signature of Funeral Service Licensee <i>Guillermo Redd</i> | | | | 22. Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Lung Cancer</u> Due to (or as a consequence of): b. <u>Coronary Heart Disease</u> Due to (or as a consequence of): c. <u>Valvular Heart Disease</u> Due to (or as a consequence of): d. <u>Chronic Obstructive Pulmonary Disease</u> | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28e. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier <i>Michael A Randolph MD</i> | | | | 29c. License number D34680 | | 29d. Date signed (Month, Day, Year) 11/17/99 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A Randolph MD 3333 N. ALBERT ST ALESS BAL MD 21218 | | | | | | | |
| | 31. Date filed (Month, Day, Year) NOV 18 1999 | | | | 32. Registrar's Signature <i>Benjamin B. Sparks</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

101100 2000 10/10/50

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

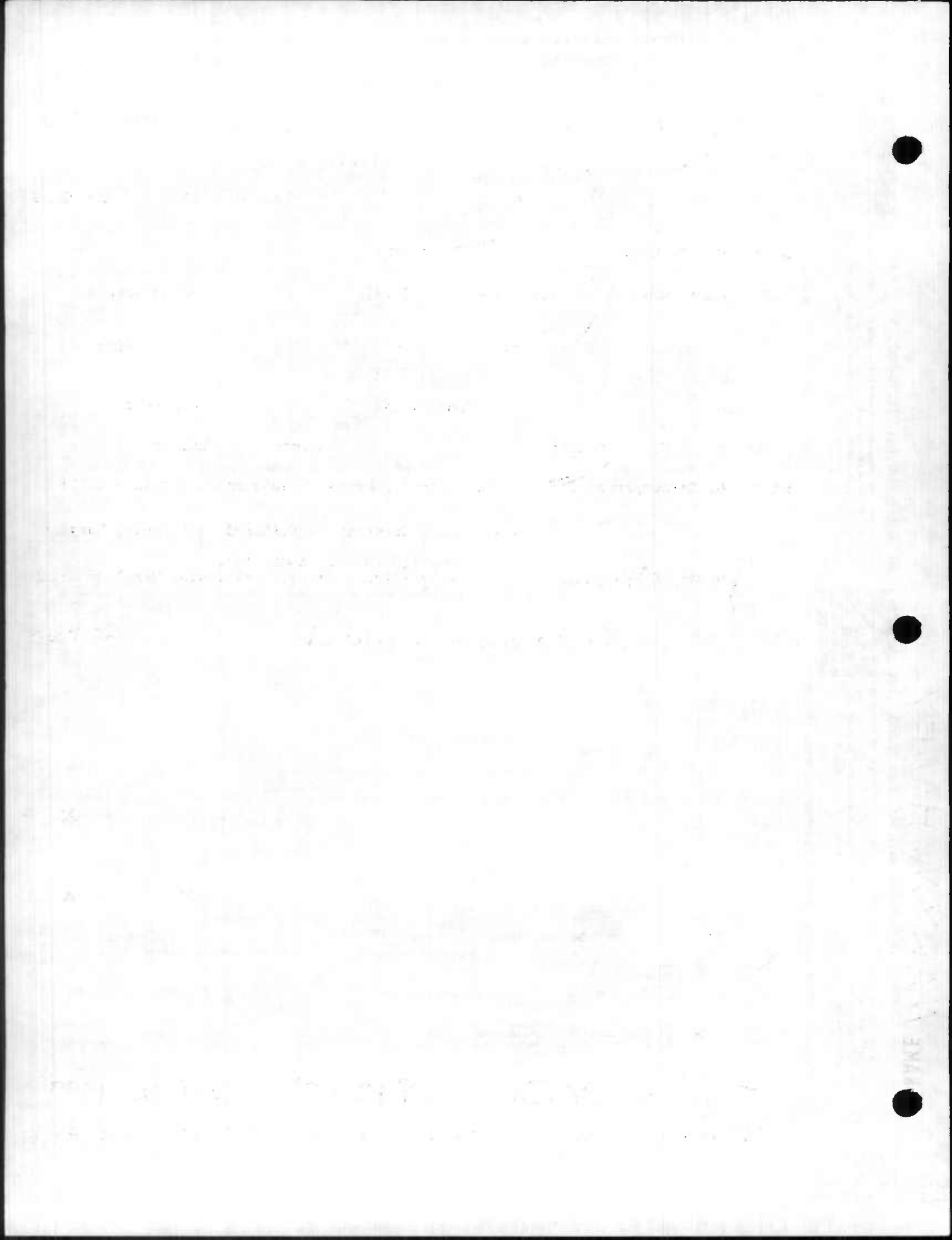
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36183

| | | | | | | | | |
|---|--|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary M. Haney | | | | 2. Date of Death Month Day Year November 12 1999 | | 3. Time of Death 1700 | |
| | 4a. Facility Name (If not institution, give street and number) St. Agnes Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 215-09-0034 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 83 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 8, 1916 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 3300 Benson Avenue De Paul House | | | | 10f. Zip Code 21227 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | |
| 17. Father's Name (First, Middle, Last) George M. Carson | | | | 18. Mother's Name (First, Middle, Maiden Summa) Jeanette Holder | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Milton G. Carson/Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1410 Scanlan Drive Glen Burnie, Maryland 21061 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery | | 20c. Location - City or Town, State 11/16/99 Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee Quanta R. Thomas | | | | 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Gangrenous Bowel Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death 60 Hours |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | | | | 28d. Describe how Injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier T. Ray M.D. | | 29c. License number P12601 | | 29d. Date signed (Month, Day, Year) Nov 12 1999 |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Todd C. Ray 900 cation Avenue Baltimore, MD 21229 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | | | 32. Registrar's Signature G. Sparks | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36184

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS M. HIGGINS

2. Date of Death

Month
NovDay
16Year
99

3. Time of Death

7:55 pm

4a. Facility Name (If not institution, give street and number)

Charlestown Care Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral
Director5. Social Security Number
169-32-96096. Sex
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)
86 Yrs.If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)
01-31-19139. Birthplace (State or Foreign
Country)
NEW YORK

Usual Residence of Decedent

10a. State
MD.10b. County
BALTIMORE10c. City, Town or Location
CATONSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

709 MAIDEN CHOICE LANE

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever In U.S.
Armed Forces?
1 ☒ Yes 2 ☐ No 1942-
If Yes, Give
Year or Dates: 197313. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.
Specify: WHITE15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
516a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

DIRECTOR OF TRAINING

16b. Kind of Business/Industry

U.S. POSTAL SERVICE

17. Father's Name (First, Middle, Last)

JAMES W. HIGGINS

18. Mother's Name (First, Middle, Maiden Surname)

MARY M. McNAMARA

19a. Informant's Name/Relationship (Type, Print)

JAMES W. BROGAN NEPHEW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2703 RAMBLER COURT, ADELPHI, MD 20783

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

METRO CREMATORY

Date

11-20
1999

20c. Location - City or Town, State

CATONSVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

4107 WILKENS AVENUE

HUBBARD FUNERAL HOME, INC. BALTIMORE, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. End stage Congestive Heart failure
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

year?

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Andres Salazar MD

29c. License number

D51051

29d. Date signed (Month, Day, Year)

November 17, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Andres Salazar 711 Maiden Choice Lane, Catonsville, MD, 21228

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

Benita B. Sparks

State
RegistrarBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Name: Thomas M. Higgins

Division of Vital Records, P.O. Box 68760,

7

021

74

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36185

| | | | | | | | | | |
|---|--|---|--|---|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GEORGE EDWARD HOHENBERGER, JR. | | | | 2. Date of Death Month Day Year NOV. 15, 1999 | | 3. Time of Death 6:30 PM | | |
| | 4a. Facility Name (If not institution, give street and number) 1311 WHITMAN DRIVE | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | 4c. County of Death ANNE ARUNDEL | | |
| Funeral Director | 5. Social Security Number 214-38-4453 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 59 Yrs. | | 8. Date of Birth (Month, Day, Year) 09-30-1940 | | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MD. | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location GLEN BURNIE | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 1311 WHITMAN DRIVE | | 10f. Zip Code 21061 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DISPATCH / STARTER | | 16b. Kind of Business/Industry U.S. GOVERNMENT | | 17. Father's Name (First, Middle, Last) GEORGE E. HOHENBERGER, SR. | | 18. Mother's Name (First, Middle, Maiden Summa) EDNA COLLISON | |
| 19a. Informant's Name/Relationship (Type, Print) BONNIE LEE HOHENBERGER WIFE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1311 WHITMAN DRIVE, GLEN BURNIE, MD 21061 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEM. PARK | | 20c. Location - City or Town, State ELKRIDGE, MARYLAND | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility 4107 WILKENS AVE. HUBBARD FUNERAL HOME, INC. BALTIMORE, MD 21229 | | 23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Esophageal Carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 1 year | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospitol: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number 047137 | | 29d. Date signed (Month, Day, Year) November, 18, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER P. RAMIREZ, MD 7845 OAKWOOD RD., GLEN BURNIE, MD 21061 | | 31. Date filed (Month, Day, Year) NOV 18 1999 | | 32. Registrar's Signature | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transportation permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36186

| | | | | | | | | |
|--|--|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GLORIA HUGHES | | | | 2. Date of Death Month Day Year NOVEMBER 16, 1999 | | 3. Time of Death 8:10 PM | |
| | 4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death RANDALLSTOWN | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 124-40-1539 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 52 Yrs. | | 8. Date of Birth (Month, Day, Year) June 29, 1947 | |
| | 9. Birthplace (State or Foreign Country) New York | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Randallstown | |
| Usual Residence of Decedent | | | | | | | | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 10e. Street and Number 3420 Chapman Road | | | | | | | | |
| 10f. Zip Code 21133 | | | | | | | | |
| 10g. Citizen of What Country? U.S.A. | | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | | | | | |
| 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | | | | | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | | | | | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -0- | | | | | | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | | | | | |
| 16b. Kind of Business/Industry Own Home | | | | | | | | |
| 17. Father's Name (First, Middle, Last) John Canavan | | | | | | | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Theresa Bowden | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Theresa Anne Bagley | | | | | | | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10812 Liberty Road Randallstown, MD 21133 | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Old Holy Family Cem. | | | | | | | | |
| 20c. Date 11/19 | | | | | | | | |
| 20d. Location - City or Town, State Randallstown, MD | | | | | | | | |
| 21. Signature of Funeral Service Licensee Stephen M Jenkins | | | | | | | | |
| 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PULMONARY FIBROSIS Due to (or as a consequence of): | | | | | | | | |
| Approximate Interval Between Onset and Death SEVERAL DAYS SEVERAL DAYS | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE PULMONARY FIBROSIS | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | | | | | |
| 28b. Time of Injury M | | | | | | | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 28d. Describe how injury occurred | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Orlando B. Conanan, MD | | | | | | | | |
| 29c. License number D 19502 | | | | | | | | |
| 29d. Date signed (Month, Day, Year) NOVEMBER 16, 1999 | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ORLANDO B. CONANAN, MD NORTHWEST HOSPITAL CENTER RANDALLSTOWN, MD 21133 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | | | | | | | |
| 32. Registrar's Signature Sparks | | | | | | | | |

MOA 1998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36187

AMENDED #26 PER MD, G777 11/18/99 DH

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

HELEN P HARRIS

2. Date of Death

Month Day Year
NOVEMBER 6 1999

3. Time of Death

7 AM

4a. Facility Name (If not institution, give street and number)

6 Ivy Lane

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

197-09-8098

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan, 19, 1999

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6 Ivy Lane

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Morris Louis Potts

18. Mother's Name (First, Middle, Maiden Surname)

Alice Bourne

19a. Informant's Name/Relationship (Type, Print)

Joann Montgomery/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

473 London Lane, Severna Park, MD 21146

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

ARTERIOSCLEROTIC CARDIOVASCULAR

5 YEARS

a. Due to (or as a consequence of):

DISEASE

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending2 ☐ Accident

investigation

3 ☐ Suicide6 ☐ Could not be4 ☐ Homicide

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. Munda MD

29c. License number

D 21776

29d. Date signed (Month, Day, Year)

NOVEMBER 9 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SURYA P. MUNDRA MD 8109 RITCHIE HWY PASADENA 21122

31. Date filed (Month, Day, Year)

NOV 18 1999

Registrar's Signature

R. Munda

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Handwritten signature

NOV 1 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36188

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Agnes Hull

2. Date of Death

November 13 1999 60:10 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

218-38-1149

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 25, 1914

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hancock

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13965 Hollow Road

10f. Zip Code

21750

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Simon Younker

18. Mother's Name (First, Middle, Maiden Surname)

Cora Bivens

19a. Informant's Name/Relationship (Type, Print)

Ralph Hull/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14019 Hollow Road Hancock, MD 21750

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Stone Bridge Brethren

Date

11/15/99 Hancock, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Grove Funeral Home, P.A.

141 W. Main St. Hancock, MD 21750-0368

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiovascular accident with

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Left hemiparesis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic cardiovascular disease

Dyslipidemia, Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Datta

29c. License number

218017

29d. Date signed (Month, Day, Year)

Nov 13, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Datta 334 Mill Street Hagerstown Maryland

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

Benjamin B. Sparks

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Home

DOS: 11/07/1999

DATTA, VASANT

NAME: HULL, DOROTHY AGNES
05/25/1914 85 / F

H265650

H3040929220

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36189

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|--------------------------|---|--|--|--|--|-------------------------------|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Michael C. Jancewski | | | | 2. Date of Death Month Day Year November 08, 1999 | | | | 3. Time of Death 6:15 AM | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Stella Maris/Mercy 301 St. Paul Place | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death | | | | | | |
| Funeral Director | 5. Social Security Number 217-05-6462 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F XX | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan 12, 1919 | | 9. Birthplace (State or Foreign Country) MD | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County | | 10c. City, Town or Location Baltimore City | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| | 10e. Street and Number 823 Umbra Street | | | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? USA | | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 44-46 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Welder | | | 16b. Kind of Business/Industry Steel Industry | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Michael Charles Goliembieski | | | | 18. Mother's Name (First, Middle, Maiden Surname) Teresa Brezinski | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Anna Jancewski/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 823 Umbra Street, Baltimore, MD 21224 | | | | | | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | | | | | | |
| | 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Non Hodgkin Lymphoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) hosp | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accidental 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | 29b. Signature and title of certifier Dr. [Signature] | | 29c. License number D40854 | | 29d. Date signed (Month, Day, Year) 11/6/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Ruseberg 301 St Paul Pl Baltimore 21202 | | | | | | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 18 1999 | | | | 32. Registrar's Signature [Signature] | | | | | | | | | | |

NOV 18 1955

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36190

Certificate of Death

Reg. No.

Amend Item#17.18 per FH G777 11/22/99 EW

#8

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rudolph Charles Janda

2. Date of Death

November 16, 1999

3. Time of Death

11:30PM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Oak Crest Care Center

4b. City, Town, or Location of Death

Parkville

4c. County of Death

Baltimore

5. Social Security Number

216-44-3328

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

08/02/1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

715 Maiden Choice Lane

10f. Zip Code

21128

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Finance Supervisor

16b. Kind of Business/Industry

United States Postal Service

17. Father's Name (First, Middle, Last)

Unknown Joseph Janda

18. Mother's Name (First, Middle, Maiden Surname)

Unknown Maria Soukup

19e. Informant's Name/Relationship (Type, Print)

Miss. Marie Lang/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

720 Camberley Circle - B3, Towson, Maryland 21204

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

11/20/99 Pikesville, Maryland

21. Signature of Funeral Service Licensee

Christina L. David

Name and Address of Facility

Leonard J. Ruck, Inc.
5305 Harford Road, Baltimore, Maryland 21214

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William M. Russell

29c. License number

D30182

29d. Date signed (Month, Day, Year)

November 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM M. RUSSELL 8800 WALTER BLVD BALTIMORE MD 21234

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

James Buchanan

James Buchanan
1803-1891

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36191

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GERTRUDE KATHERINE KIDD

2. Date of Death

Month Day Year
NOV. 16, 1999

3. Time of Death

10:30 AM

4a. Facility Name (If not institution, give street and number)

4600 REHBAUM AVENUE

4b. City, Town, or Location of Death

HALETHORPE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

217-38-7674

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
11-30-1907

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTIMORE

10c. City, Town or Location

HALETHORPE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4600 REHBAUM AVENUE

10f. Zip Code

21227

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

FRANK B. WOODEN

18. Mother's Name (First, Middle, Maiden Surname)

LAURA I. MYERS

19a. Informant's Name/Relationship (Type, Print)

KENNETH W. KIDD SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4600 REHBAUM AVE., BALTIMORE, MD 21227

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DRUID RIDGE CEMETERY

Date

11-20
1999

20c. Location - City or Town, State

PIKESVILLE, MARYLAND

21. Signature of Funeral Service Licensee

Jackie D. Shannon

22. Name and Address of Facility

4107 WILKENS AVENUE
HUBBARD FUNERAL HOME, INC. BALTIMORE, MD 21229

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1-2 wks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arteriosclerotic coronary disease
Due to (or as a consequence of):

years

c. Hypertension
Due to (or as a consequence of):

years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Laurence R. Gallagher, MD

29c. License number

D01786

29d. Date signed (Month, Day, Year)

Nov. 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAURENCE GALLAGHER MD 716 MAIDEN CHOICE LANE, BALTIMORE, MD 21228

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED #23a PER MD, G777 11/18/99 DH/dhb Certificate of Death

Reg. No.

99 36192

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Anna Kline

2. Date of Death

October 28, 1999

3. Time of Death

12:30 pm

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

218-50-7180

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 16, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

8903 Mavis Avenue

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
5th gradeCollege (1-4or 5+)
N/A

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Homemaking-Own Home

17. Father's Name (First, Middle, Last)

Peter A. Comes

18. Mother's Name (First, Middle, Maiden Surname)

Anna Tremper

19a. Informant's Name/Relationship (Type, Print)

Patricia A. Parkhurst

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19719 Gunpowder Rd. Millers, Md. 21102

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Joseph Church Cemetery 1030-99 Fullerton, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

E. F. Lassahn Funeral Home
11750 Belair Rd. Kingsville, Md. 21087

23a. Part I. Enter the diagnosis, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cardiorespiratory arrest

Approximate Interval Between Onset and Death

15 minutes

Due to (or as a consequence of):

b. ARDS

Due to (or as a consequence of):

15 days

c. SEPSIS

Due to (or as a consequence of):

15 days

d. LUNG CANCER

2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Bryan S. Nolan M.D.

29c. License number

D 25542

29d. Date signed (Month, Day, Year)

October 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bryan Nolan M.D. 5601 Loch Raven Blvd. 21239

31. Date Filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

Bryan S. Nolan

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1912

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36193

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elsie D. Klausmeyer

2. Date of Death

November 13, 1999

3. Time of Death

8:30 AM

4e. Facility Name (If not institution, give street and number)

Manor Care Rossville

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-01-7963

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

11/12/1901

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

39 1/2 Greenwood Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Andrew Metzger

18. Mother's Name (First, Middle, Maiden Surname)

Wanda Monath

19a. Informant's Name/Relationship (Type, Print)

Norma Chelton/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

39 1/2 Greenwood Avenue Baltimore, Maryland 21206

20e. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oaklawn, Cemetery

Date

11/16/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility John C. Miller Inc.

6415 Belair Road Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Cardiac arrhythmias

Due to (or as a consequence of):

b.

Ischemic Cardiomyopathy

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1-2 wks.

unknown -

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HTN, Malnutrition, Arthritis

ASCVD

23b. Did tobacco use contribute to the causes of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28e. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-38754

29d. Date signed (Month, Day, Year)

11-15-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIKA WASCER. 406 EASTERN BLVD.

M.D - 21221

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

11-24
LAD-

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36194

| | | | | | | | | |
|--|--|--|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edythe M. McCleary | | | | | 2. Date of Death Month Day Year NOVEMBER 17, 1999 | | 3. Time of Death 9:40 PM |
| | 4a. Facility Name (If not institution, give street and number) SAINT JOSEPH MEDICAL CENTER | | | | | 4b. City, Town, or Location of Death TOWSON | | 4c. County of Death BALTIMORE |
| Funeral Director | 5. Social Security Number 218-07-6687 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 96 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) MAY 30, 1903 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Towson | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 7001 N. Charles Street | | | | 10f. Zip Code 21204 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | |
| 17. Father's Name (First, Middle, Last) Mark Santmyer | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sadie Unk. | | | |
| 19a. Informant's Name/Relationship (Type, Print) George McCleary/son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18330 Augusta Dr. Monument, CO 80132 | | | | |
| 20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 11/18/99 | | | 20c. Location - City or Town, State Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee Edward A. Gregorchik | | | | 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 1 day |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Dr. Bulcinski | | | | 29c. License number D-12849 | | 29d. Date signed (Month, Day, Year) 11-18-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AH. GHILADI, MD, 7600 OSLER Dr. TOWSON, MD 21204 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | 32. Registrar's Signature [Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature

GEORGE J. VON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36195

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|---|-------------------------------|---|----------------------------------|--------------------------------|----------------------------------|--|--------------------------------------|--|----------------------------------|----|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Veto A. Maxen | | | | 2. Date of Death Month: November Day: 15 Year: 1999 | | 3. Time of Death 12:10 PM | | | | | | | | | | | | |
| | 4e. Facility Name (If not institution, give street and number) St. Agnes Hospital | | | | 4b. City, Town, or Location of Death Baltimore, MD | | 4c. County of Death n/a | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 219-14-1760 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 74 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 3, 1925 | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County n/a | | 10c. City, Town or Location Baltimore | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 3640 Hineline Road | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician | | 16b. Kind of Business/Industry Commercial Const. | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Anthony Maxen | | | | 18. Mother's Name (First, Middle, Maiden Surname) Unknown | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Frederick L. Frank / Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 Dellview Drive, Finksburg, Maryland 21048 | | | | | | | | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park | | 20c. Location - City or Town, State Elkridge, Maryland | | 20d. Date 11/19 | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee <i>R. C. Snyder</i> | | | | 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>e. <i>Respiratory Failure</i></td> <td rowspan="4">Approximate Interval Between Onset and Death <i>2 days</i></td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b. <i>Aspiration Pneumonia</i></td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c. <i>Cerebral Vascular Accident</i></td> <td rowspan="3"></td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | e. <i>Respiratory Failure</i> | Approximate Interval Between Onset and Death <i>2 days</i> | Due to (or as a consequence of): | b. <i>Aspiration Pneumonia</i> | Due to (or as a consequence of): | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. <i>Cerebral Vascular Accident</i> | | Due to (or as a consequence of): | d. |
| | Immediate Cause (Final disease or condition resulting in death) | e. <i>Respiratory Failure</i> | Approximate Interval Between Onset and Death <i>2 days</i> | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | |
| b. <i>Aspiration Pneumonia</i> | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. <i>Cerebral Vascular Accident</i> | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Myocardial Infarction</i> | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Thomas Balshi MD</i> | | | | 29c. License number P13594 | | 29d. Date signed (Month, Day, Year) November 15 1999 | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Balshi, MD, 900 Caton Avenue, Baltimore, Maryland 21229 | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: MAXEN, Veto A.

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36196

| | | | | | | | | |
|--|---|---|--|--|---|---|---|--|
| Physician (Medical Examiner) | 1. Decedent's Name (First, Middle, Last) MYRTLE V. MOORE | | | | 2. Date of Death Month Day Year NOVEMBER 14, 1999 | | 3. Time of Death 6:30 AM | |
| | 4a. Facility Name (If not institution, give street and number) 1504 SAPPINGTON DRIVE | | | | 4b. City, Town, or Location of Death GAMBRILLS | | 4c. County of Death ANNE ARUNDEL | |
| Funeral Director | 5. Social Security Number 219-28-1778 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 67 Yrs. | | 8. Date of Birth (Month, Day, Year) APRIL 17, 1932 | |
| | 9. Birthplace (State or Foreign Country) PENNSYLVANIA | | 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location MILLERSVILLE | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 470 SKI LANE | | 10f. Zip Code 21108 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEKEEPER | | 16b. Kind of Business/Industry HOSPITAL | | | | |
| 17. Father's Name (First, Middle, Last) HARRY W. HENDERSHOT | | | | 18. Mother's Name (First, Middle, Maiden Surname) FLORENCE PITTMAN | | | | |
| 19a. Informant's Name/Relationship (Type, Print) GARY MOORE- SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1504 SAPPINGTON DRIVE, GAMBRILLS, MD 21054 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK | | 20c. Location - City or Town, State 11/19/99 GLEN BURNIE, MD | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) e. <i>Metastatic carcinoma of</i> Due to (or as a consequence of): f. <i>Pancreas</i> Due to (or as a consequence of): g. <i>severe Chronic obstructive</i> Due to (or as a consequence of): h. <i>lung disease</i> i. <i>cor pulmonale</i> | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <i>Son's Home</i> | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Stewart C. [Signature]</i> MD | | 29c. License number D19171 | | 29d. Date signed (Month, Day, Year) 11/16-99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 795 1700 East Road Glen Burnie, MD 21061 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item#32 perDVR G777 11/18/99 EW
Amended Item#26 perPHYG777 11/18/99 EW

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36197

| | | | | | | | | | | | |
|---|--|---------------------------|---|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Crumbwell Miller | | | | | | 2. Date of Death Month Nov Day 7 Year 1999 | | 3. Time of Death 8:00AM | | |
| | 4a. Facility Name (If not institution, give street and number) 18 Benkert Ave. | | | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NIA | | |
| Funeral Director | 5. Social Security Number 250-30-9462 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 6, 1923 | | 9. Birthplace (State or Foreign Country) S. Carolina | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County NIA | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 18 Benkert Ave. | | | | | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steel Worker | | | | 16b. Kind of Business/Industry Steel | | | |
| 17. Father's Name (First, Middle, Last) Smiley Miller Jr. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Nellie Horton | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Bertha Miller - Wife | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Benkert Ave. Balto, MD. 21229 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Veterans 11-15-99 Owings Mills, MD. | | | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Gary P. March Funeral Home P.A. 4401 Fredrickson Pass Balto., MD. 21229 | | | | | | | |
| 23a. PM/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrest Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | 28d. Describe how injury occurred | | | | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier RJ Walsh | | | | 29c. License number D38662 | | | |
| | | | | 29d. Date signed (Month, Day, Year) 11/10/99 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard J. Walsh 4660 Wilkens Ave. Baltimore, Maryland 21229 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) | | | | 32. Registrar's Signature NOV 18 1999  | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

| | | | | | | | | | | |
|---|---|--|---|---------------------------------|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) KHAYLAN R. MONTROSE | | | | | | 2. Date of Death Month Day Year NOVEMBER 13, 1999 | | 3. Time of Death 0142 AM | |
| | 4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | 4c. County of Death ANNE ARUNDEL | | | |
| Funeral Director | 5. Social Security Number 218-55-7340 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) Yrs. 21 | | 8. Date of Birth (Month, Day, Year) August 25 1999 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Glen Burnie | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 139 Faywood Drive, Apt. E. | | | | 10f. Zip Code 21060 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (14 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A | | | 16b. Kind of Business/Industry N/A | | |
| | 17. Father's Name (First, Middle, Last) Gordon R. Montrose | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marcia Beaton | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Gordon R. Montrose (father) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 139 Faywood Drive, Apt E. Glen Burnie, MD. 21060 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenwood Cemetery | | Date 11/18 | | 20c. Location - City or Town, State Brooklyn, New York | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD. 21122 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MYOCARDITIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number O.C.M.E. | | | 29d. Date signed (Month, Day, Year) NOVEMBER 14, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chutem 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | 32. Registrar's Signature | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36199

| | | | | | | | | |
|--|--|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Daniel Nathans | | | | 2. Date of Death Month Day Year NOV 16, 1999 | | 3. Time of Death 9:00 AM | |
| | 4a. Facility Name (If not institution, give street and number) 2227 Crest Road | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 222-16-7692 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 71 Yrs. | | 8. Date of Birth (Month, Day, Year) OCT 30, 1928 | |
| | 9. Birthplace (State or Foreign Country) Delaware | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 2227 Crest Road | | 10f. Zip Code 21209 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Microbiologist | | 16b. Kind of Business/Industry Medical School | | | | |
| 17. Father's Name (First, Middle, Last) Samuel Nathans | | | | 18. Mother's Name (First, Middle, Maiden Summa) Sarah Levitan | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Joanne G. Nathans/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2227 Crest Road Baltimore, MD 21209 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 11/17/99 | | 20c. Location - City or Town, State Baltimore, MD | | | | |
| 21. Signature of Funeral Service Licensee Edward A. Gregorchik | | 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CNS Bleed - low Platelets Due to (or as a consequence of): b. acute myelocytic leukemia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death INSTANT 2 yrs | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Philep Burke MD | | 29c. License number 10004218 | | 29d. Date signed (Month, Day, Year) 11/16/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D.J. Burke Johns Hopkins Cancer Center - 600N Wolfe St, Baltimore, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | 32. Registrar's Signature [Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NOT A COPY OF THE ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36200

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN JAMES O'DONNELL

2. Date of Death

NOVEMBER 15, 1999 10:10AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

231-16-6288

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept 29, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore County

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

803 Quincy Road

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No WW2
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Golfing Pro

16b. Kind of Business/Industry

Golf Course

17. Father's Name (First, Middle, Last)

Francis Joseph O'Donnell

18. Mother's Name (First, Middle, Maiden Surname)

Nan Brady

19a. Informant's Name/Relationship (Type, Print)

Mrs. Michelle A. O'Donnell (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

803 Quincy Road, Baltimore, Maryland 21286

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veterans, Garrison

Date

11/19/99 Garrison, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Martin D. Lawson

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road, Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CONGESTIVE HEART FAILURE DUE TO

Approximate Interval Between Onset and Death

1 YEAR

a. Due to (or as a consequence of):

CORONARY ARTERY DISEASE

YEARS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Natividad D. de Leon, M.D.

29c. License number

D 19508

29d. Date signed (Month, Day, Year)

Nov. 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATIVIDAD D. DELEON M.D. 7601 OSLER DRIVE, TOWSON MARYLAND 21204

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

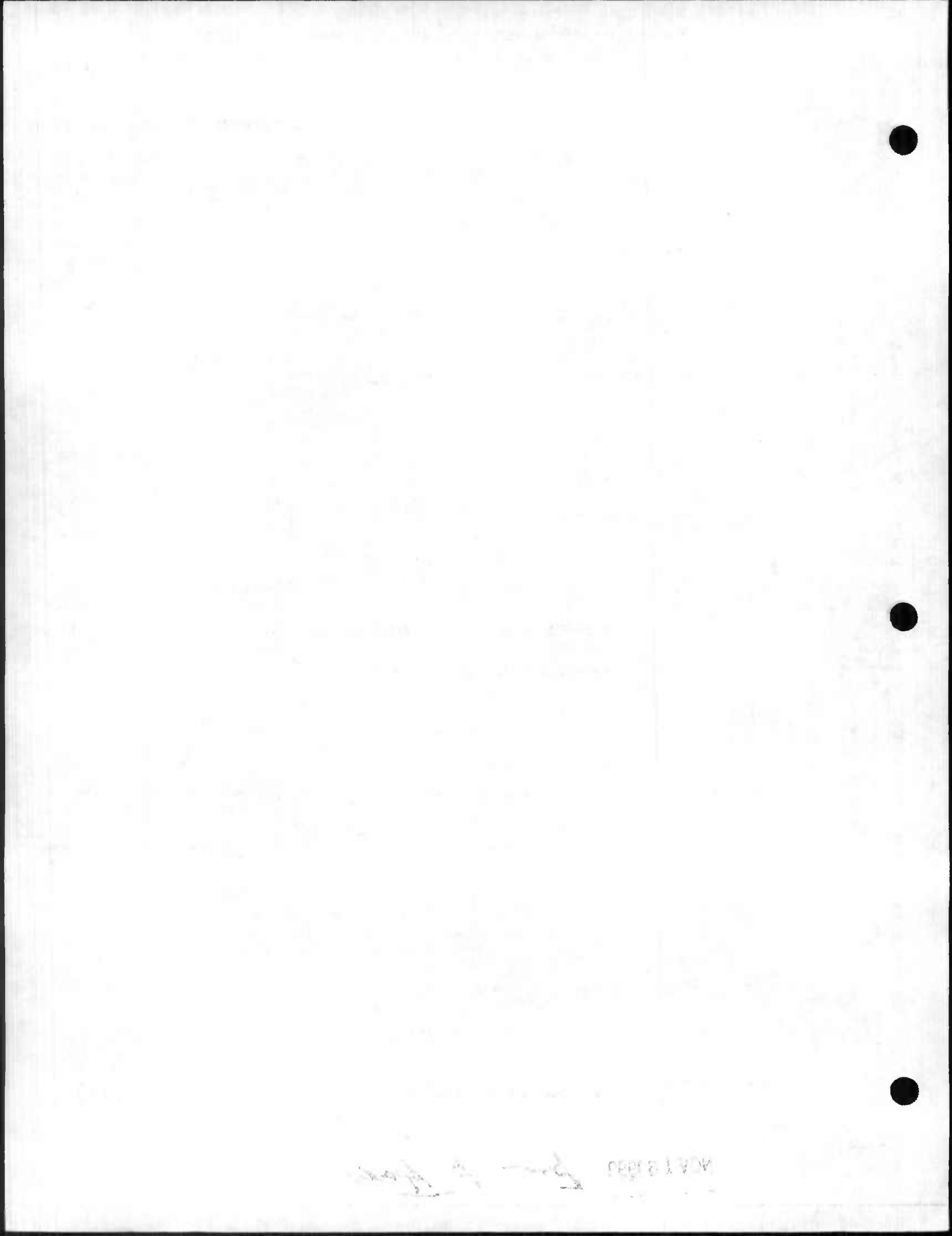
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36201**

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KENNETH EVERETTE Oxford

2. Date of Death

Nov. 9 1999 10:15P

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

808 N. MONROE Street

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

212-24-9162

6. Sex

M 20 F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 19, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

808 N. MONROE Street

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1950-1952

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12 YEARS

College (1-4 or 5+) 1 YEAR

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MECHANIC

16b. Kind of Business/Industry

Amoco Service Station

17. Father's Name (First, Middle, Last)

ROBERT

18. Mother's Name (First, Middle, Maiden Surname)

Martha Oxford

19a. Informant's Name/Relationship (Type, Print)

Edith Oxford Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

808 N. MONROE Street BALTIMORE, Md 21217

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Forest Veterans Cemetery

Date

11/16/99 Swings Mills, Md

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

CHATHAM - HARRIS H. 5340 REISTERSTOWN ROAD BALTIMORE, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Prostate Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D26256

29d. Date signed (Month, Day, Year)

11/11/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BICH DUONG TOU WASHINGTON BLVD BALTIMORE MD 21230

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36202

| | | | | | | | | |
|--|--|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Daniel Ray Pippin | | | | 2. Date of Death Month Day Year NOV 15, 1999 | | 3. Time of Death 9:10 PM | |
| | 4a. Facility Name (If not institution, give street and number) Cromwell Genesis Eldercare | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 233-62-6772 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 57 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) MAY 9, 1942 | |
| | | | | | | | 9. Birthplace (State or Foreign Country) West Virginia | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 3506 Wheelhouse Road | | | | 10f. Zip Code 21220 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1960/1966 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Aviation Machinist | | | 16b. Kind of Business/Industry Aerospace | |
| 17. Father's Name (First, Middle, Last) Walter E. Pippin | | | | 18. Mother's Name (First, Middle, Maiden Surname) Nora Hobbs | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Anette J. Pippin/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3506 Wheelhouse Rd. Baltimore, MD 21220 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 11/17/99 | | Date 11/17/99 | | 20c. Location - City or Town, State Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee Edward A. Gregorchik | | | | 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): LUNG CANCER SMOKING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death 2 months YEARS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D52279 | | 29d. Date signed (Month, Day, Year) 11/16/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SRIRAM H. BALASUBRAMANIAN 4920 Campbell BLVD MD 21239. | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | | | 32. Registrar's Signature General G. Sparto | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Handwritten signature or initials.

NOV 15 1904

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36203

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LINTON BENJAMIN PUMPHREY | | | | 2. Date of Death Month Day Year NOV 13, 1999 | | 3. Time of Death 3:03pm | |
| | 4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | 4c. County of Death AA COUNTY | |
| Funeral Director | 5. Social Security Number 216-12-3865 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) SEPT. 10, 1919 | |
| | Usual Residence of Decedent | | 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location SEVERNA PARK | |
| To Be Completed by Funeral Director | 10e. Street and Number 41 MCKINSEY ROAD, APARTMENT 119 | | | | 10f. Zip Code 21146 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPERVISOR | | 16b. Kind of Business/Industry TAXES | |
| | 17. Father's Name (First, Middle, Last) LINTON ABRAHAM PUMPHREY | | | | 18. Mother's Name (First, Middle, Maiden Surname) EMMA W. REINECKE | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) MS. BETTY PUMPHREY (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8104 FOXBERRY LANE, APT. 1418, PASADENA, MD. 21122 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK | | 20c. Location - City or Town, State 11/17/99 GLEN BURNIE, MD. | | 20d. Date | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Michael C. Sapp | | | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ventricular fibrillation Due to (or as a consequence of): Acute myocardial infarction Due to (or as a consequence of): Coronary artery disease Due to (or as a consequence of): Approximate Interval Between Onset and Death 60 min 1 hour 10 yrs. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 28f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier General Blum | | | |
| | 29c. License number 001865 | | | | 29d. Date signed (Month, Day, Year) 11/16/99 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GERMAN CUNYCH 8 BRAGG AVE BETH SEVERNA PARK MD 21146 | | | | | | | |
| | 31. Date filed (Month, Day, Year) NOV 18 1999 | | | | 32. Registrar's Signature B. Spots | | | |

ORIGINAL

Handwritten text at the bottom of the page, possibly a signature or date, followed by the printed text "Page 8 of 10".

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36204

AMENDED #1, PER MD,G777 11/18/99 DH

Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) JAMES MATTHEW PETERSEN | | 2. Date of Death Month OCTOBER Day 27 Year 1999 | | 3. Time of Death 1926 | |
| 4a. Facility Name (If not institution, give street and number) John Hopkins Hospital | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death |
| 5. Social Security Number 229-83-7382 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) Yrs. 8 Months 17 Days 17 | 8. Date of Birth (Month, Day, Year) Feb. 10, 1999 | | 9. Birthplace (State or Foreign Country) Virginia |
| Usual Residence of Decedent | | | | | |
| 10a. State Va. | 10b. County Prince William | 10c. City, Town or Location Manassas | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 7303 Mariposa Drive | | 10f. Zip Code 20112 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) None | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None | | 16b. Kind of Business/Industry None | | | |
| 17. Father's Name (First, Middle, Last) Mark O. Petersen | | | 18. Mother's Name (First, Middle, Maiden Surname) Annette M. McCallum | | |
| 19a. Informant's Name/Relationship (Type, Print) (Parents) Mark & Annette Petersen | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7303 Mariposa Drive, Manassas, Virginia 20112 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Stonewall Memory Gardens | | 20c. Location - City or Town, State Oct 30, 1999 Manassas, Virginia | |
| 21. Signature of Funeral Service Licensee <i>Deborah Price</i> | | 22. Name and Address of Facility Price Funeral Home, Inc. 9609 Center Street, Manassas, Virginia 20110 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last a. pulmonary edema Due to (or as a consequence of): b. congestive heart failure Due to (or as a consequence of): c. congenital heart disease Due to (or as a consequence of): d. | | | | | Approximate Interval Between Onset and Death one day four days eight months |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, lecture, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>James Petersen MD</i> | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) OCTOBER 27, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEANETTE R. WHITE, MD 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND 21287 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | 32. Registrar's Signature <i>James Petersen</i> | | | |

Handwritten text, possibly a signature or date, located in the center of the page.

Handwritten signature or initials at the bottom left of the page.

NOV 18 1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36205

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Milton L. Quick

2. Date of Death

Nov. 16, 1999

3. Time of Death

6:30 AM

4a. Facility Name (If not institution, give street and number)

St. Elizabeth Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

212-05-8949

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 15, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

919 Rockhill Avenue

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

Charles Quick

18. Mother's Name (First, Middle, Maiden Surname)

Jenny Leonard

19a. Informant's Name/Relationship (Type, Print)

Judy A. Corigliano / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5823 Jasmine Circle, E. Syracuse, New York 13057

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Maryland Veterans Ceme.

Date

11/19

20c. Location - City or Town, State

Crownsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hubbard Funeral Home, Inc.

4107 Wilkens Avenue, Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

metastatic prostate carcinoma

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D32158

29d. Date signed (Month, Day, Year)

11/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jyoti Parikh MD 821 N. Eutaw St, suite 407, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36206

| | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary R. Rice | | | | 2. Date of Death Month Day Year November 12 1999 | | | | 3. Time of Death 7:10 AM | | |
| | 4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | | | 4c. County of Death ANNE ARUNDEL | | |
| Funeral Director | 5. Social Security Number 220-14-6728 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) July 15, 1918 | | 9. Birthplace (State or Foreign Country) New York | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Severn | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 1355 Severn Road | | | | 10f. Zip Code 21144 | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home maker | | | | 16b. Kind of Business/Industry Own home | | | |
| 17. Father's Name (First, Middle, Last) Frederick Nauman | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marie Unknown | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Robert E. Rice, Jr. / Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1355 Severn Road, Severn, Maryland 21144 | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park | | Date 11/15 | | 20c. Location - City or Town, State Elkridge, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death) a. <i>Pneumonia</i> Due to (or as a consequence of): | | | | | | | | | | 2 D. | |
| b. <i>Congestive heart failure</i> Due to (or as a consequence of): | | | | | | | | | | 2 | |
| c. <i>Cardiomyopathy</i> Due to (or as a consequence of): | | | | | | | | | | 2 | |
| d. | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Babak Imamoel</i> | | | | 29c. License number H0053939 | | | | 29d. Date signed (Month, Day, Year) 11/12/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Babak Imamoel, MD 301 Hospital Drive, Glen Burnie, Maryland 21061 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | 32. Registrar's Signature <i>Benita B. Sparks</i> | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36207

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | | |
|---|--|---|---|--|--|---|--|--|-------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last) Vernon W. Reddish | | | | | | 2. Date of Death Month Day Year November 16, 1999 | | | 3. Time of Death 2:20 PM | |
| 4a. Facility Name (If not institution, give street and number) Genesis Elder Care | | | | | | 4b. City, Town, or Location of Death Severna Park | | | 4c. County of Death Anne Arundel | |
| 5. Social Security Number 215-03-7266 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) May 5, 1914 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Severna Park | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 24 Truck House Road | | | | 10f. Zip Code 21146 | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Welder | | | 16b. Kind of Business/Industry Steel Manufacturing | | | |
| 17. Father's Name (First, Middle, Last) William Thomas Reddish | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ruth L. Bradley | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Gladis Bowling sister | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5608 Loch Raven Blvd. Apt. A Baltimore, MD 21239 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Cemetery | | | Date Nov. 19 | | 20c. Location - City or Town, State Glen Burnie, Maryland | | |
| 21. Signature of Funeral Service Licensee <i>Mitchell</i> | | | | | | 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 | | | | |
| 23a. Permit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. DEMENTIA Due to (or as a consequence of): b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANOXIC ENCEPHALOPATHY | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>S. Munda MD</i> | | 29c. License number D21776 | | 29d. Date signed (Month, Day, Year) NOVEMBER 17 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUCHA MUNDRA MD 3001 S HANOVER ST BALTIMORE 21225 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | 32. Registrar's Signature <i>James A. Sparks</i> | | | | | | | | |

ORIGINAL

Handwritten signature

100-1-100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Unk. 99-255 Amend Item#3 perPHYG7912/10/1999/EN State of Maryland / Department of Health and Mental Hygiene

Linda Kay Randall

AMEND ITEMS: #23 PART I, 27, 28A-F PER Certificate of Death

MEO G777 11-19-99 WR. 99 36208

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Linda Kay Randall

2. Date of Death
Month Day Year
October 26 1999
3. Time of Death
P.M.
07:16 AM

4a. Facility Name (If not institution, give street and number)

Kenilworth and I95 North

4b. City, Town, or Location of Death

Greenbelt

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

unknown

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

40 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 6, 1959

9. Birthplace (State or Foreign Country)

Unknown

Usual Residence of Decedent

10a. State

unknown

10b. County

unknown

10c. City, Town or Location

unknown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No
unknown

10e. Street and Number

unknown

10f. Zip Code

unknown

10g. Citizen of What Country?

unknown

11. Marital Status

unknown

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates: unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (14 or 5+)

unknown

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Sumama)

unknown

19a. Informant's Name/Relationship (Type, Print)

O.C.M.E.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 Penn Street Baltimore, MD 21201

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify)

in state

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

MULTIPLE INJURIES

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Scene

27. Manner of Death

1 ☐ Natural2 ☒ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day, Year)

10-26-99

28b. Time of

Injury

7:11

P

M

28c. Injury at

Work?

1 ☐ Yes 2 ☒ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

INTERSTATE

28d. Describe how injury occurred

PEDSTRIAN

STRUCK BY VEHICLE(S)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)KENILWORTH &
I-95 NORTH, GREENBELT, MD29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore M. King

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

October 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE M. KING

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

NOV 8 1 40 PM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36209
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marvin Simmons

2. Date of Death

Month Day Year

Nov. 13 99

3. Time of Death

12:10 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

333 S. Pulaski Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

218-03-4000

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 10, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

333 S. Pulaski Street

10f. Zip Code

21223

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Brakeman

16b. Kind of Business/Industry

Railroad

17. Father's Name (First, Middle, Last)

Thomas Simmons

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Unknown

19a. Informant's Name/Relationship (Type, Print)

Florence Simmons (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

333 S. Pulaski Street Baltimore, MD 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crownsville Vets.

Date

11/17/99

20c. Location - City or Town, State

Crownsville, MD

21. Signature of Funeral Service Licensee

Sharon Mayhew

22. Name and Address of Facility

Ambrose Funeral Home 21227
2719 Hammonds Ferry Rd Landowne, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic carcinoma of the colon

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Type 2 diabetes mellitus, Hypertension
Cardiomyopathy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. Evans MD

29c. License number

00020040

29d. Date signed (Month, Day, Year)

11/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Evans MD, 700 Washington Blvd., Baltimore, MD 21230

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Handwritten signature

NOV 18 1938

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36210

| | | | | | | | | |
|---|---|---|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HANS ERIC STEIN | | | | 2. Date of Death Month Day Year November 15 1999 | | 3. Time of Death 1:57 pm | |
| | 4a. Facility Name (If not institution, give street and number) Stella Maris | | | | 4b. City, Town, or Location of Death Timonium | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 214-12-1927 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F XX | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) June 2, 1913 | |
| | 9. Birthplace (State or Foreign Country) Germany | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Lutherville | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No XX | | 10e. Street and Number 8607 Countrybrooke Way | | 10f. Zip Code 21093 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/President | | 16b. Kind of Business/Industry Textile Co. | | | | |
| 17. Father's Name (First, Middle, Last) Anton Stein | | | | 18. Mother's Name (First, Middle, Maiden Summa) Irma Rothchild | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Amalia R Stein Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8607 Countrybrooke Way Lutherville, Maryland 21093 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens | | 20c. Date 11/20/99 | | 20d. Location - City or Town, State Lutherville, Maryland | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ALZHEIMER'S Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. Dua to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <i>[Signature]</i> <i>[Signature]</i> | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number D 15504 | | 29d. Date signed (Month, Day, Year) 11-15-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified in accordance with the regulations.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME: STEIN, HANS

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

15

Handwritten text, possibly a signature or date, is visible in the center of the page.

Handwritten text at the bottom left, possibly a signature.

NOV 18 1980

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36211

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EDWARD EARL STILLMAN | | | | 2. Date of Death Month Day Year November 16 1999 | | 3. Time of Death 10:45 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | 4c. County of Death ANNE ARUNDEL | |
| Funeral Director | 5. Social Security Number 244-20-3880 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 74 Yrs. | 8. Under 1 Year Months Days | 9. Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JULY 24, 1925 | | 9. Birthplace (State or Foreign Country) NORTH CAROLINA |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location GLEN BURNIE | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 7633 9TH COURT | | | | 10f. Zip Code 21061 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1944- If Yes, Give Year or Dates: 46 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BUS DRIVER | | 16b. Kind of Business/Industry TRANSPORTATION | | | |
| | 17. Father's Name (First, Middle, Last) JOHN MILLARD STILLMAN | | | | 18. Mother's Name (First, Middle, Maiden Summa) LOAR MAY KEECH | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) KATHLEEN POTTER- SISTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7633 9TH COURT, GLEN BURNIE, MARYLAND 21061 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK | | 20c. Date 11-19-99 | | 20d. Location - City or Town, State GLEN BURNIE, MD | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, PA. 1 SECOND AVE., S.W., GLEN BURNIE, MD 21061 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SQUAMOUS CELL LUNG CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| State Registrar | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier [Signature] MD | | | | 29c. License number D43977 | | 29d. Date signed (Month, Day, Year) November 16 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie, 301 Hospital Ave, Glen Burnie, MD 21061 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | | | 32. Registrar's Signature [Signature] | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36212

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Andrew Howard Solli | | | | 2. Date of Death Month: November Day: 14, Year: 1999 | | 3. Time of Death 3:00 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) University of Maryland Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 213-18-3414 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept 16, 1919 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Carroll | | 10c. City, Town or Location Hampstead | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 2545 Bert Fowler Road | | 10f. Zip Code 21074 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): -0- | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) General Superintendent | | 16b. Kind of Business/Industry Construction | | | | |
| 17. Father's Name (First, Middle, Last) Hans Solli | | | | 18. Mother's Name (First, Middle, Maiden Surname) Kristine Moun | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Velma Solli | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2545 Bert Fowler Road Hampstead, MD 21074 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Mem. Park | | 20c. Date 11/19 | | 20d. Location - City or Town, State Sykesville, MD | | |
| 21. Signature of Funeral Service Licensee <i>Stephen M Jenkins</i> | | | | 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Subdural hemorrhage</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 11-13-99 | | 28b. Time of Injury 1256 P M | | 28c. Injury at Work? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred SUBJECT FELL. | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) 2384 FAIRMOUNT CARROLLO | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Koume M. Y. H. H.</i> | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) November 15, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. KOREW HUN. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36213

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|--|--|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ISAAC SHIVERS | | | | 2. Date of Death Month: NOV Day: 15 Year: 1999 | | 3. Time of Death 9 45 PM | |
| | 4a. Facility Name (If not institution, give street and number) BON SECOURS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 219-56-4472 | | 6. Sex <input type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 48 Yrs. | If Under 1 Year Months: Days: | If Under 24 Hrs. Hours: Min: | 8. Date of Birth (Month, Day, Year) FEB. 9. 1951 | 9. Birthplace (State or Foreign Country) MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number MILLENNIUM HEALTH ABD REHAB. 1217 W. FAYETTE STREET | | | | 10f. Zip Code 21223 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. AFRO-AMERICAN Specify: | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HEALTH CARE PROVIDER | | | 16b. Kind of Business/Industry NURSING HOME | |
| 17. Father's Name (First, Middle, Last) HOWARD SHIVERS SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname) IRENE EURE | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MARCEL HALL/SISTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8009 REMINGTON AVE. BALTO, MD. 21244 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY | | Date NOV. 22, 1999 | | 20c. Location - City or Town, State BALTO, MD. | | |
| 21. Signature of Funeral Service Licensee <i>Bernadine V. Scruggs</i> | | | | 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO, MD. 21213 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ADULT IMMUNE DEFICIENCY SYNDROME/complications 4 YRS Due to (or as a consequence of): Pneumonia 72 hr Encephalopathy 18 months Dilatation of Esophagus 2 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. malnutrition | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Shillineau MD</i> | | | | 29c. License number D25055 | | 29d. Date signed (Month, Day, Year) 11/17/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT J WILLIAMS 5602 BALTIMORE NATIONAL PIKE BALTO MD 21228 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

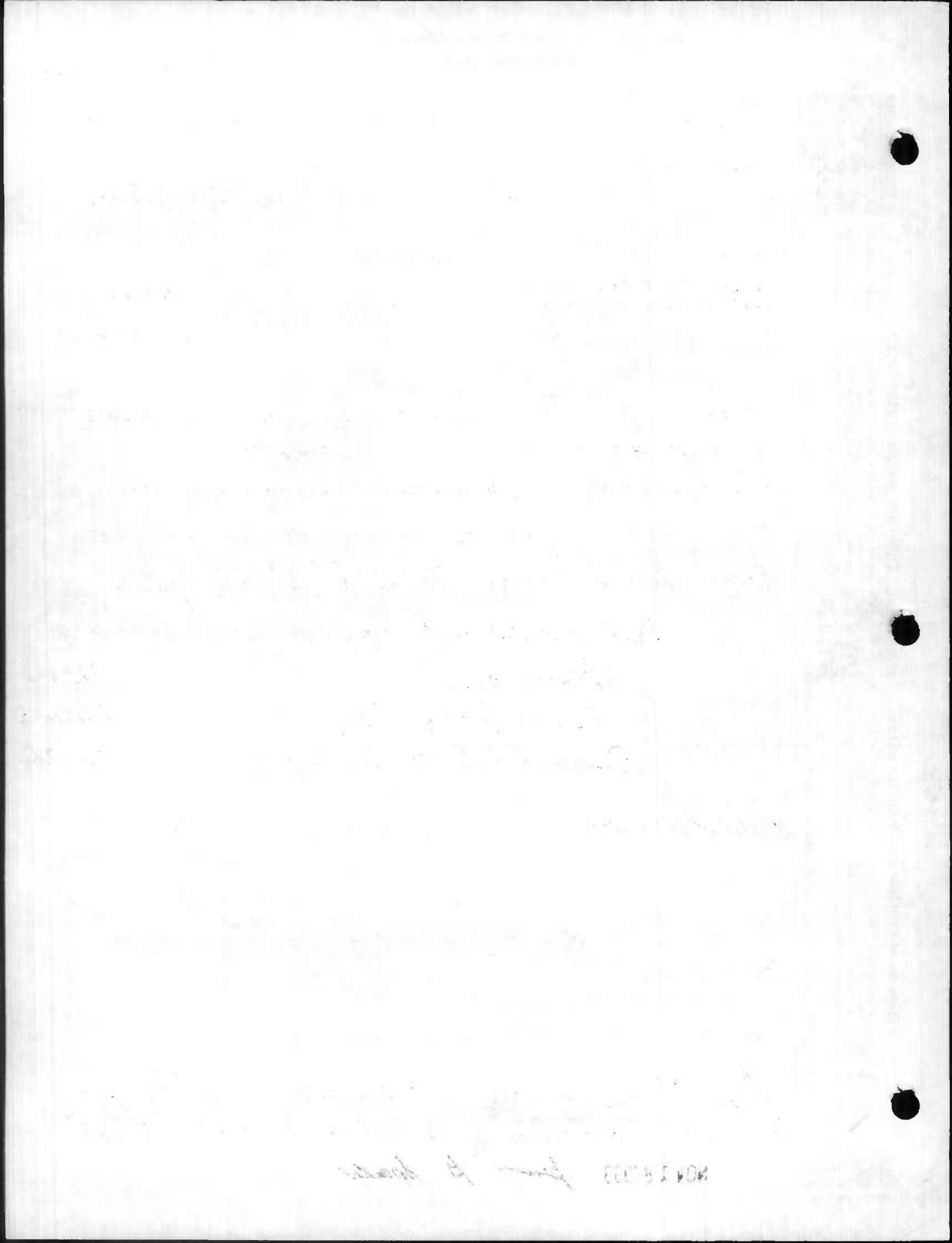
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36214

| | | | | | | | | |
|---|--|---------------------------------|---|---|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARLENE STIERHOFF | | | | 2. Date of Death Month 11 Day 17 Year 99 | | 3. Time of Death 6:50 AM | |
| | 4a. Facility Name (If not institution, give street and number) 24 Byway Rd. | | | | 4b. City, Town, or Location of Death Owings Mills | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 216-28-2397 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 68 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 16, 1931 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Owings Mills | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 24 Byway Rd. | | | | 10f. Zip Code 21117 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dispatcher | | 16b. Kind of Business/Industry Baltimore Co. Public Schools Transportation | | |
| 17. Father's Name (First, Middle, Last) Harry Green | | | | 18. Mother's Name (First, Middle, Maiden Surname) Daisy Griswald | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Harry H. Stierhoff - husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 Byway Rd. Owings Mills, Md. 21117 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) LakeView Mem. Park Nov. 19, 1999 | | 20c. Location - City or Town, State Sykesville, Md. | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, Md. 21117 | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Renal Cell Carcinoma. | | | | | | | Approximate Interval Between Onset and Death 4 months |
| | Due to (or as a consequence of): | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): | | | | | | | |
| | c. Due to (or as a consequence of): | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | 29c. License number D33759 | | 29d. Date signed (Month, Day, Year) 11/17/99 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARIF HUSSAIN, 22 S. GREENE ST., Baltimore, MD 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the report is a general
description of the project and its objectives.
2. The second part is a detailed description of the
methodology used in the study.
3. The third part is a description of the results
of the study.
4. The fourth part is a discussion of the results
and their implications.
5. The fifth part is a conclusion and a list of
references.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

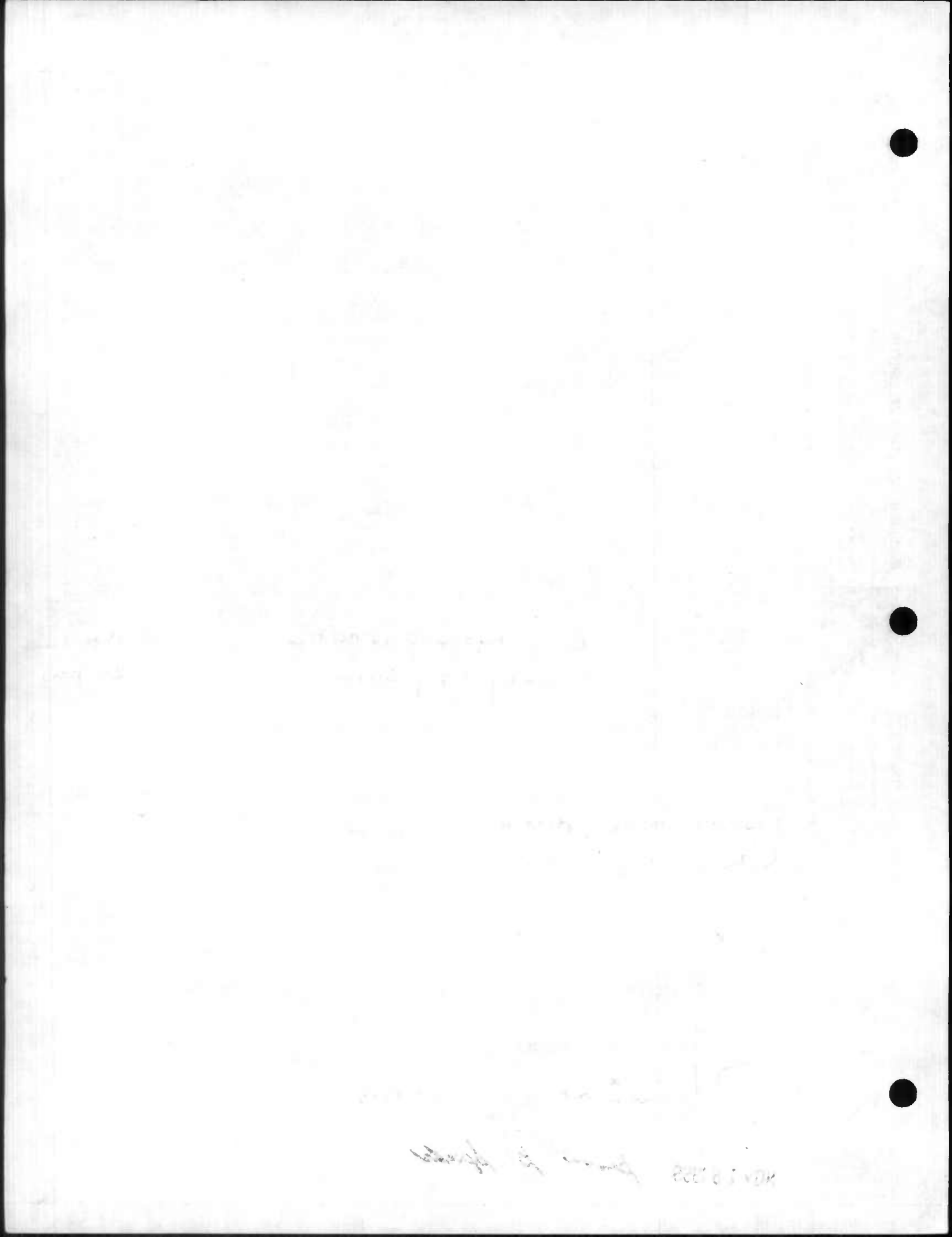
Certificate of Death

Reg. No. 99 36215

| | | | | | | | | | | |
|---|--|--------------------------|---|---|---|-------------------------------|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Henry Stelmack | | | | 2. Date of Death Month Day Year November 16 1999 | | | | 3. Time of Death 5:30 PM | |
| | 4a. Facility Name (If not institution, give street and number) 1948 Frames Rd | | | | 4b. City, Town, or Location of Death Dundalk | | | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 219-22-2728 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 71 Yrs. | | 8. Date of Birth (Month, Day, Year) June 14 1928 | | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Dundalk | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 1948 Frames Rd | | | | 10f. Zip Code 21222 | | | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Diesel mechanic | | | | 16b. Kind of Business/Industry Trucking | | |
| 17. Father's Name (First, Middle, Last) Joseph Stelmack | | | | 18. Mother's Name (First, Middle, Maiden Surname) Laura Kowalski | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Constance Stelmack /wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1948 Frames Rd Baltimore, MD 21222 | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | | Date Nov 19 1999 | | 20c. Location - City or Town, State Catonsville, MD | | |
| 21. Signature of Funeral Service Licensee Anthony C. Connolly | | | | 22. Name and Address of Facility Connolly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death Minutes 20 years | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostate Cancer, Metastatic Coronary Artery Disease | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and Title of certifier | | | 29c. License number D36430 | | 29d. Date signed (Month, Day, Year) November 17, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey Richardson, M.D. 1792 Merritt Blvd Baltimore, MD 21222 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | | | | | | | | | |
| 32. Registrar's Signature | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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AMEND ITEM: 20B PER F.H. G777 11-29-99 WR. State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #1, MD, G777 11-29-99 WR.

Certificate of Death

Reg. No.

99 36216

Physician
/Medical
Examiner

Funeral
Director

| | | | | |
|--|--|---|--|---|
| 1. Decedent's Name (First, Middle, Last) ELEANOR MARIE STANTON Eleanor Stanton | | 2. Date of Death Month Day Year November 17 1999 | | 3. Time of Death 2:30 AM |
| 4a. Facility Name (If not institution, give street and number) Genesis - Heritage Center | | 4b. City, Town, or Location of Death Dundalk | | 4c. County of Death Baltimore |
| 5. Social Security Number 217-14-2509 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | 8. Date of Birth (Month, Day, Year) Dec 12, 1922 | 9. Birthplace (State or Foreign Country) MD |
| Usual Residence of Decedent | | | | |
| 10a. State MD | 10b. County Baltimore | 10c. City, Town or Location Dundalk | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number 6819 Bessemer Ave | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? USA |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | |
| 17. Father's Name (First, Middle, Last) George O'Bryan | | 18. Mother's Name (First, Middle, Maiden Surname) Clara Cramblett | | |
| 19a. Informant's Name/Relationship (Type, Print) George Stanton /son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3421 Liberty Pkwy. Baltimore, MD 21222 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery | | 20c. Location - City or Town, State Baltimore, MD |
| 21. Signature of Funeral Service Licensee Anthony C. Connelly | | 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; align-items: flex-start;"> <div style="margin-right: 10px;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div> <p>a. PNEUMONIA (ASPIRATION)</p> <p>b. CEREBELLAR DEGENERATION</p> <p>c.</p> <p>d.</p> </div> </div> | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| 29b. Signature and title of certifier K. S. J. HARMASINA, M.D. | | 29c. License number D17753 | | 29d. Date signed (Month, Day, Year) 11-17-99 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. S. J. HARMASINA, M.D. 710 CHURCH ST. BALTIMORE, MD 21225. | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | 32. Registrar's Signature [Signature] | | |

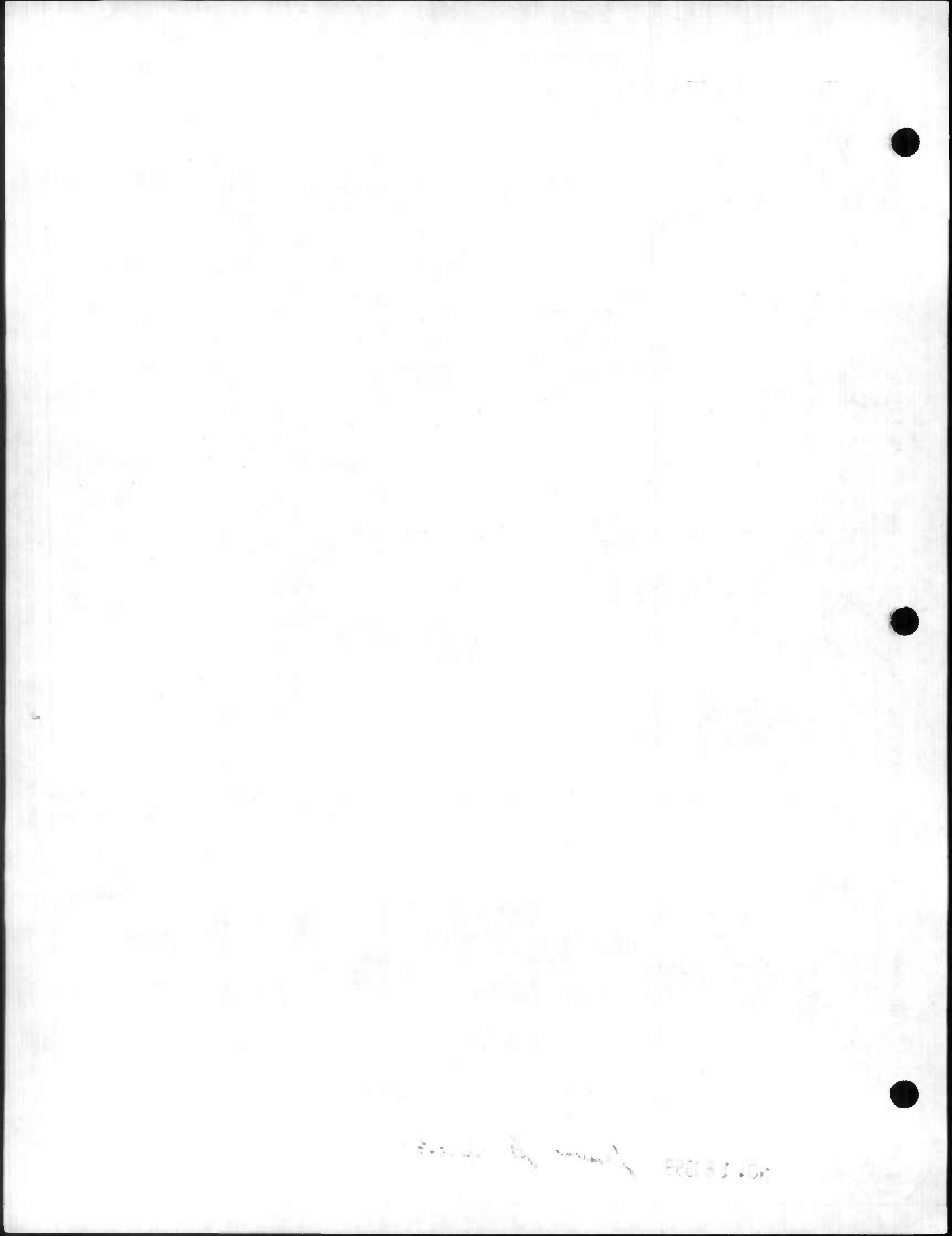
To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36217

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LARRY

TRUESDALE

2. Date of Death

Month Day Year
NOVEMBER 12, 1999

3. Time of Death

5:26 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE, CITY

4c. County of Death

N.A.

5. Social Security Number

214 567782

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10-6-51

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State
Md

10b. County

N.A.

10c. City, Town or Location

Balt.

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1032 New Hope Circle

10f. Zip Code

21202

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

9th

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Constitution

16b. Kind of Business/Industry

MAN POWER

17. Father's Name (First, Middle, Last)

Paul Truesdale

18. Mother's Name (First, Middle, Maiden Surname)

Viola Jingles

19a. Informant's Name/Relationship (Type, Print)

Carrie Truesdale

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4024 St. Clair Lane 21213

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Garrison Forest

Date

11/22/99

20c. Location - City or Town, State

Crown Mills, Md

21. Signature of Funeral Service Licensee

Joseph B. Locke

22. Name and Address of Facility

Joseph B. Locke Jr 3/1 1304 N. Central Ave

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Alcoholic Hepatitis

Due to (or as a consequence of):

2 weeks

b. Hepatorenal syndrome

Due to (or as a consequence of):

2 weeks

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Retroviral syndrome

Hepatitis B + C

Schizophrenia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

K. Fairbanks PHYSICIAN

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

November 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kyrstan Fairbanks, Johns Hopkins Hospital 600 N. Wolfe St. Balti, MD 21287

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-1000.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36218

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DAVID

TOOMEY

2. Date of Death

Month

Day

Year

November 15, 1999

3. Time of Death

4:36 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

219-02-8617

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

16 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11/23/1982

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9 Raylene Ct.

10f. Zip Code

21061

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Student

16b. Kind of Business/Industry

High School

17. Father's Name (First, Middle, Last)

David Michael Toomey, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Peggy Brown

19a. Informant's Name/Relationship (Type, Print)

David M. Toomey, Sr. / Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 Raylene Ct. Glen Burnie MD 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial

Date

11/16/1999

20c. Location - City or Town, State

Dorsey, Maryland

21. Signature of Funeral Service Licensee

Sean D. Suber

22. Name and Address of Facility

Ambrose Funeral Home
2719 Hammonds Ferry Rd. Lansdowne MD 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. hypoxic ischemic brain injury

Due to (or as a consequence of):

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. cardiac arrest

Due to (or as a consequence of):

3 days

c. pulmonary hemorrhage

Due to (or as a consequence of):

3 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

cystic fibrosis, lung transplant

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jennifer J. Schwettz MD

29c. License number

D0051118

29d. Date signed (Month, Day, Year)

November 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jennifer J. Schwettz, MD 600 North Wolfe St., Baltimore MD 21287

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

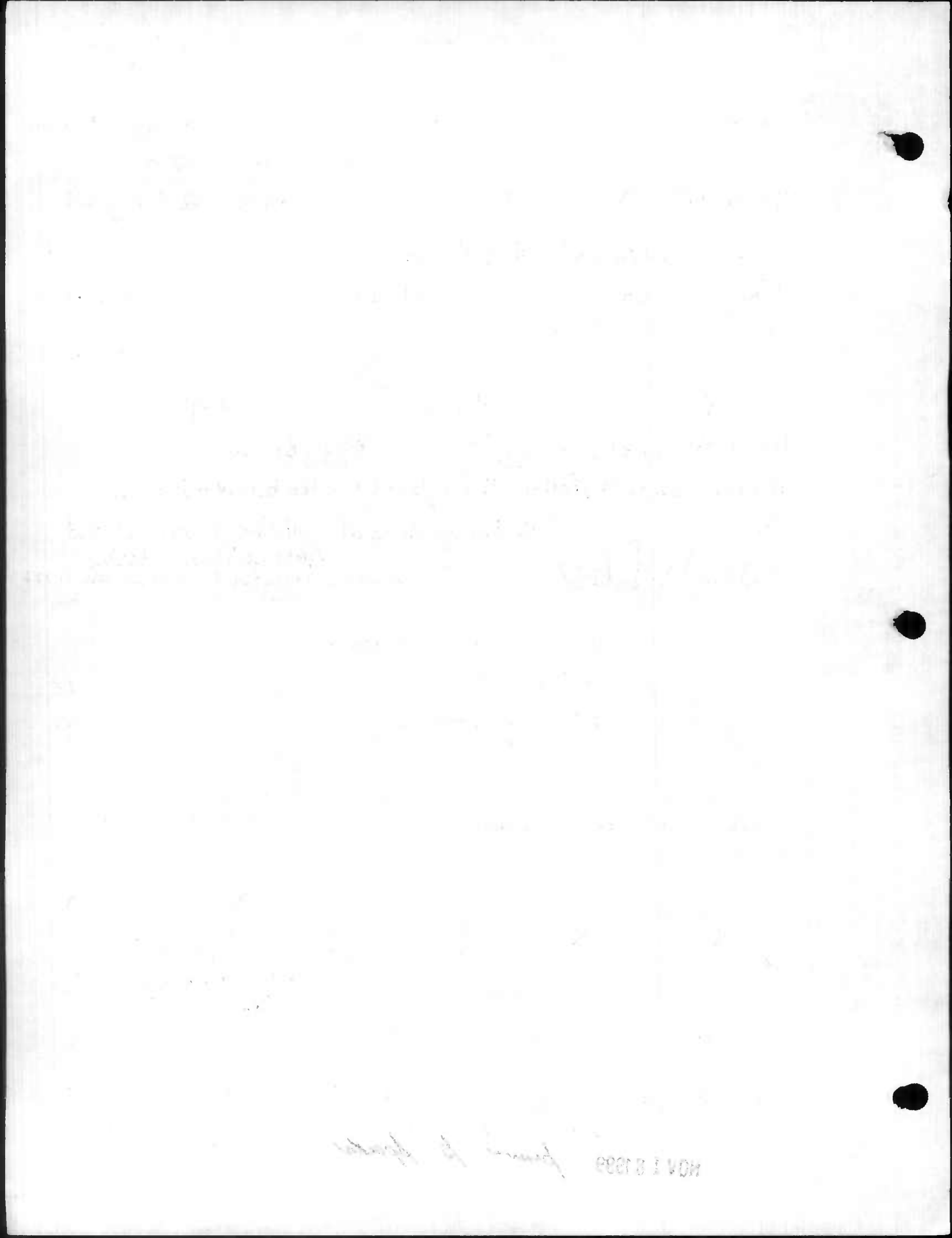
Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36219**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARTIN DAVID TRUESDALE, SR.

2. Date of Death

November 13, 1999

3. Time of Death

1:57am

4a. Facility Name (If not institution, give street and number)

STELLA MARIS @ MERCY HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

214-50-9689

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

51 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

9-17-48

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1636 HOLBROOK ST.

10f. Zip Code

21202

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

-12-

College (1-4 or 5+)

-0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ELECTRONICS TECHNICIAN

16b. Kind of Business/Industry

ELECTRICAL

17. Father's Name (First, Middle, Last)

JOSEPH TRUESDALE

18. Mother's Name (First, Middle, Maiden Surname)

GWENDOLYN SCOTT

19a. Informant's Name/Relationship (Type, Print)

MICHAEL TRUESDALE (BROTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

215 SHENANDOAH AVE. BALTIMORE, MARYLAND 21225

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VETERANS 11-18-99 OWINGS MILLS, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jonathan D. Hiza

22. Name and Address of Facility

PHILLIPS FUNERAL HOME, P.A.
1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Metastatic Lung Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify) *hospw*

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Ray M

29c. License number

D40554

29d. Date signed (Month, Day, Year)

11/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dana Roseberg 301 St Paul Pl Baltimore MD 21202

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

[Signature]

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Truesdale, Martin
Baltimore, Maryland 21215-0020

AH

[Handwritten signature]

2001 B. J. W. W.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36220

| | | | | | | | | | |
|--|---|--|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Joseph L. Venanzi | | | | 2. Date of Death Month Day Year November 15, 1999 | | 3. Time of Death 10:05 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 219-16-2663 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 74 Yrs. | | 8. Date of Birth (Month, Day, Year) March 15, 1925 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number 5026 Frankford Avenue | | 10f. Zip Code 21206 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic (Electrical) | | | 16b. Kind of Business/Industry City of Baltimore | | |
| 17. Father's Name (First, Middle, Last) Louis Venanzi | | | | 18. Mother's Name (First, Middle, Maiden Surname) Julia Carlontonia | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Frances M. Venanzi/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5026 Frankford Avenue Baltimore, Maryland 21206 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cemetery | | | 20c. Date 11/18/99 | | 20d. Location - City or Town, State Baltimore, Maryland | |
| 21. Signature of Funeral Service Licensee Duffy M. Blum | | | | 22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Hyperviscosity Due to (or as a consequence of): b. Multiple myeloma Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| Approximate Interval Between Onset and Death 2 DAYS | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | | 28d. Describe how Injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier G. Samello MD | | | | 29c. License number D47390 | | | 29d. Date signed (Month, Day, Year) November 15, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IVAN BORRELLIO, M.D. 9000 Franklin Square Drive Baltimore MD. 21237 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36221

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ALOYSIUS WALSH | | | | 2. Date of Death Month Day Year NOVEMBER 14, 1999 | | 3. Time of Death 7:12 PM | |
| | 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 213-03-6087 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 82 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) MAR 27, 1917 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 524 North Charles Street | | | 10f. Zip Code 21202 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNK. | | | 16b. Kind of Business/Industry UNK. | |
| | 17. Father's Name (First, Middle, Last) Aloysius J. Walsh, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Hanley | | | |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print) Eugene A. Walsh/nephew | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13208 Constitutional Ave. Ocean City, MD 21842 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | Date 11/16/99 | | 20c. Location - City or Town, State Baltimore, MD | |
| | 21. Signature of Funeral Service Licensee  Thomas Gregor | | | | 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SUSPECTED MYOCARDIAL INFARCTION a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| Physician /Medical Examiner | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 11/14/99 | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| State Registrar | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier  | | | | 29c. License number D 001 5452 | | 29d. Date signed (Month, Day, Year) 11/15/99 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) C. TIMOTHY BESSENT, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 | | | | | | | |
| | 31. Date filed (Month, Day, Year) NOV 18 1999 | | | | 32. Registrar's Signature  | | | |

Handwritten signature and date: FEB 5 1904

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36222

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM A. WELNOSKY, JR.

2. Date of Death
Month Day Year
NOVEMBER 14, 19993. Time of Death
12:38 AM

4a. Facility Name (If not institution, give street and number)

VETERANS ADMINISTRATION HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-44-8100

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

JULY 28, 1944

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6701 WHITE WATER COURT #203

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1961-1965

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PIPEFITTER

16b. Kind of Business/Industry

CHEMICAL COMPANY

17. Father's Name (First, Middle, Last)

WILLIAM A. WELNOSKY, SR.

18. Mother's Name (First, Middle, Maiden Surname)

ETHEL SEWELL

19a. Informant's Name/Relationship (Type, Print)

SCOTT WELNOSKY - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2404 CHETWOOD CIRCLE, TIMONIUM, MD 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARYLAND VETERANS CEMETERY

Date

11/18/99 CROWNSVILLE, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

SINGLETON FUNERAL HOME, PA.

1 SECOND AVE., S.W., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hepatic encephalopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

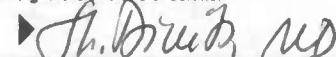
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

P13373

29d. Date signed (Month, Day, Year)

November 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARA DINITS 10 N Greene street Baltimore MD 21201

31. Date filed (Month, Day Year)

NOV 18 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten text at the bottom of the page, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36223

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thornton Mason Wood

2. Date of Death

November 16, 1999 8:50 PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

577-12-8804

6. Sex

XXM 2□ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

December 16, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Long Green

10d. Inside City Limits

1□ Yes 2X No

10e. Street and Number

13025 Manor Road

10f. Zip Code

21057-9628

10g. Citizen of What Country?

United States

11. Marital Status

1□ Never Married 2X Married
3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

X□ Yes 2□ No
If Yes, Give Year or Dates: 6/42
6/46

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Special Agent

16b. Kind of Business/Industry

FBI

17. Father's Name (First, Middle, Last)

Robert Louis Wood

18. Mother's Name (First, Middle, Maiden Surname)

Sara Annabel Mason

19a. Informant's Name/Relationship (Type, Print)

Mrs. Jean A. Wood / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13025 Manor Road Long Green, MD 21057-9628

20a. Method of Disposition

1□ Burial 2X Cremation 3□ Removal from State
4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Serv. Corp.

Date

11/18/99

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

Stephen A. Coster

22. Name and Address of Facility

1050 York Road

Ruck Towson Funeral Home, Inc.

Towson, Maryland 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTIC SHOCK

Due to (or as a consequence of):

b. RIGHT MIDDLE AND LOWER LOBE PNEUMONIA

Due to (or as a consequence of):

c. ASPIRATION

Due to (or as a consequence of):

d. HEAD AND NECK RESECTION FOR LOCALLY METASTATIC SQUAMOUS CELL CANCER

Approximate Interval Between Onset and Death

8 hours

36 hours

9 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1X Yes 2□ No 3□ Probably 4□ Unknown

24a. Was an autopsy performed?

1□ Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2□ No

25. Was case referred to medical examiner?

1□ Yes 2X No

26. Place of Death (Check only one)

Hospital: 1X Inpatient 2□ ER/Outpatient 3□ DOA

Other:

4□ Nursing Home 5□ Residence 6□ Other (Specify)

27. Manner of Death

1X Natural 5□ Pending investigation
2□ Accident 6□ Could not be determined
3□ Suicide
4□ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Walter H. Hines MD

29c. License number

DZ3450

29d. Date signed (Month, Day, Year)

11/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WALTER HEPNER MD 3346 PAPERMILL RD. PHOENIX MD 21131

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

Barbara G. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Thornton, M Wood
Baltimore, Maryland 21215-0020
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36224

| | | | | | | | | | | | |
|---|---|--|--|---|---|--|--|--|--|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ROBERT WHYE | | | | 2. Date of Death Month 11 Day 14 Year 99 | | | | 3. Time of Death 1532 | | |
| | 4a. Facility Name (If not institution, give street and number) BALTIMORE VETERANS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death BALTIMORE CITY | | |
| Funeral Director | 5. Social Security Number 219 42 9847 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 54 Yrs. | | 8. Date of Birth (Month, Day, Year) SEPT. 17, 1945 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County BALTIMORE | | 10c. City, Town or Location Towson | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 292 Eudowood Lane | | | | 10f. Zip Code 21286 | | 10g. Citizen of What Country? USA | | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Vietnam Era | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER | | | 16b. Kind of Business/Industry Private Business | | | |
| | 17. Father's Name (First, Middle, Last) ANNON WHYE | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Gladys Mc NEIL | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Gladys Whye / MOTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 292 Eudowood Lane Towson, Maryland 21286 | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Veterans Cem. | | | | Date 11-18-99 | | 20c. Location - City or Town, State Owings Mills, Md | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility CHA TOWAN - HARRIS F.H. 5240 REISTERSTOWN ROAD BALTIMORE, MD 21215 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death |
| | <div style="display: flex;"> <div style="flex: 1;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>ACIDEMIA</p> <p>Due to (or as a consequence of):</p> </div> <div style="flex: 1;"> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>MULTISYSTEM ORGAN FAILURE</p> <p>Due to (or as a consequence of):</p> </div> </div> | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> M.D. | | | | | | 29c. License number D0054861 | | 29d. Date signed (Month, Day, Year) NOVEMBER 14th 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT F. CORDER | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36225

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|--|--|--|--|--|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ROSA E. WHITE | | | | 2. Date of Death Month Day Year NOV 12 1999 | | 3. Time of Death 6:10 PM | | |
| | 4a. Facility Name (If not institution, give street and number) MILLENNIUM @ LIBERTY HEIGHTS NURSING CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 170-20-7648 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 105 Yrs. | | 8. Date of Birth (Month, Day, Year) JULY 19, 1894 | | |
| | 9. Birthplace (State or Foreign Country) MD. | | 10. Usual Residence of Decedent 10a. State: MD. 10b. County: N/A 10c. City, Town or Location: BALTIMORE | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 10e. Street and Number 1617 EUTAW PLACE | | 10f. Zip Code 21217 | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): -8- College (1-4 or 5+): -0- | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE | | 16b. Kind of Business/Industry DOMESTIC | | | | | |
| 17. Father's Name (First, Middle, Last) RICHARD TONGUE | | | | 18. Mother's Name (First, Middle, Maiden Surname) OLIVIA TONGUE | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) OLIVIA AYERS (NIECE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1617 EUTAW PLACE BALTIMORE, MARYLAND 21217 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK | | Date 11-17-99 | | 20c. Location - City or Town, State BALTIMORE, MARYLAND | | | |
| 21. Signature of Funeral Service Licensee <i>Jonathan D. Hibner</i> | | | | 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. <i>Thrombocytopenia</i> Due to (or as a consequence of): b. <i>anemia</i> Due to (or as a consequence of): c. <i>Dementia</i> Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 month 10 yrs 15 yrs | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number D 36494 | | 29d. Date signed (Month, Day, Year) 11/15/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K DESAIA 4660 Wilkins Ave Baltimore MD 21227 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2028:204

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36226

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jerome Joseph Zarachowicz

2. Date of Death

Month Day Year
NOVEMBER 15, 1999

3. Time of Death

07:01 AM

4a. Facility Name (If not institution, give street and number)

VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death

FORT HOWARD

4c. County of Death

Funeral
Director

5. Social Security Number

220-36-8342

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

58

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MARCH 26, 1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4315 Springwood Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Tool and Die Maker

16b. Kind of Business/Industry

Steel Company

17. Father's Name (First, Middle, Last)

Edward Zarachowicz

18. Mother's Name (First, Middle, Maiden Surname)

Cecelia Buczkowski

19a. Informant's Name/Relationship (Type, Print)

Barbara Zarachowicz/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4315 Springwood Avenue Baltimore, Maryland 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Rosary Cemetery

Date

11/18/99 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

John C. Miller Inc.

6415 Belair Road Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

BRAIN TUMOR

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Aurora C. Tan, M.D.

29c. License number

D14958

29d. Date signed (Month, Day, Year)

NOVEMBER 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aurora C. Tan, MD 9600 North Point Rd Fort Howard, MD 21052

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

[Signature]

State
Registrar

ORIGINAL

AKA: JEROME J. ZARACHOWICZ

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician
/Medical
ExaminerFuneral
Director

Reg. No.

3. Time of Death

4a. Facility Name (If not institution, give street and number)

4b. City, Town, or Location of Death

4c. County of Death

5. Social Security Number

6. Sex

7. Age (In yrs. last birthday)

8. Date of Birth

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

10e. Street and Number

10f. Zip Code

10g. Citizen of What Country?

11. Marital Status

12. Was Decedent Ever in U.S.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

14. Race - American Indian, Black, White, etc.

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Surname)

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical examiner?

Hospital:

26. Place of Death (Check only one)

27. Manner of Death

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36227

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Spencer G. Avent

2. Date of Death

November 16, 1999

3. Time of Death

5:55 AM

4a. Facility Name (If not institution, give street and number)

4608 Eugene Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

552-14-3657

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Sept. 7, 1913

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4608 Eugene Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Captain

16b. Kind of Business/Industry

Merchant Marine

17. Father's Name (First, Middle, Last)

Spencer Garland Avent Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Thorne

19a. Informant's Name/Relationship (Type, Print)

Mrs. Waltraud Avent (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4608 Eugene Avenue, Baltimore, Maryland 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer

Date

11/17/99 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Mark T. Rosen

22. Name and Address of Facility

Schimunek Funeral Home Inc.
3331 Brehms Lane, Baltimore, Maryland 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Adenocarcinoma of unknown Primary Origin

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W. Vanderpool MD MPH

29c. License number

D52420

29d. Date signed (Month, Day, Year)

11/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. Vanderpool MD MPH 3400 Brehms Lane Baltimore MD 21212

31. Date filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

B. Smith

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36228

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS ANDERSON, SR.

2. Date of Death

November 15 1999

3. Time of Death

7:25 PM

4a. Facility Name (If not institution, give street and number)

St. Agnes Healthcare

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219-30-0746

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

01-06-35

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10 S. CULVER STREET

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 TH GRADE

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

UNDER WRITER

16b. Kind of Business/Industry

INSURANCE

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

MATTIE CHATMAN

19a. Informant's Name/Relationship (Type, Print)

FRANCES ANDERSON WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 S. CULVER ST., BALTO. MD. 21229

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LOU DON PARK CEMETERY

Date

11-22-99

20c. Location - City or Town, State

BALTO. MD

21. Signature of Funeral Service Licensee

Vaughn C. H.

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO. NATL PIKE, BALTO. MD. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrest

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

years

c. Status Post aortic aneurysm repair

Due to (or as a consequence of):

weeks

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Resident

29c. License number

P10874

29d. Date signed (Month, Day, Year)

November 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elie K. Fraiji, Jr. St. Agnes Healthcare Department of Surgery Baltimore, MD 21229

31. Date filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.State
Registrar

05/11/2000

99 36229

ORIGINAL

Handwritten signature or scribble

2001 2 1 VOW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36230

| | | | | | | | | |
|--|--|---|---|--|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GERTRUDE LEVINA BEALE | | | | 2. Date of Death Month Day Year November 15, 1999 | | 3. Time of Death 8:15 a.m. | |
| | 4a. Facility Name (If not institution, give street and number) Sunbridge Care | | | | 4b. City, Town, or Location of Death Elkton | | 4c. County of Death Cecil | |
| Funeral Director | 5. Social Security Number 215-28-6118 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 92 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) March 20, 1907 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Harford | | 10c. City, Town or Location Bel Air | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 326 Choice Street | | | | 10f. Zip Code 21014 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4th grade College (1-4or 5+) College | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | |
| 17. Father's Name (First, Middle, Last) George Edward Myers | | | | 18. Mother's Name (First, Middle, Maiden Surname) Florence Virginia Howard | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Eva E. Hynes (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 326 Choice Street, Bel Air, MD 21014 | | | | |
| 20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park | | Date 11/17/99 | | 20c. Location - City or Town, State Elkridge, Maryland | | |
| 21. Signature of Funeral Service Licensee Bryan C. Williams | | | | 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD 21014 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 3 YEARS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE CARCINOMA OF COLON | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, lecture, office building, etc. (Specify) | | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Sunbridge MD | | | | 29c. License number D45344 | | 29d. Date signed (Month, Day, Year) 11/16/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESH DHANJANI MD, 6225 UNION AVE, HAVRE DE GRACE, MD 21078 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | | | 32. Registrar's Signature [Signature] | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36231

Amended Items #23a, 24a, 25, 26, 27, 29 per Phy 6777 11/19/99

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|----------------------------------|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) MARY B. BIRCKHEAD | | | | 2. Date of Death Month October Day 18 Year 1999 | | 3. Time of Death 8:30 am | |
| 4a. Facility Name (If not institution, give street and number) Friends Nursing home | | | | 4b. City, Town, or Location of Death Sandy Spring | | 4c. County of Death Montgomery | |
| 5. Social Security Number 009-01-9782 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 24, 1914 | |
| 9. Birthplace (State or Foreign Country) MD | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MD | 10b. County Montgomery | 10c. City, Town or Location Sandy Spring | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 17401 Norwood Road | | 10f. Zip Code 20860 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Occupational Therapist | | | | 16b. Kind of Business/Industry Medical | |
| 17. Father's Name (First, Middle, Last) Lennox Birckhead | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Buchanan Albert | | | |
| 19a. Informant's Name/Relationship (Type, Print) Taylor Brickhead/brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Farview Road, Baltimore, MD 21212 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee  Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street, Baltimore, MD 21201 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Clinical C.V.A. Cerebrovascular Accident</p> <p>Due to (or as a consequence of):</p> <p>b. Multi Infarct Dementia</p> <p>Due to (or as a consequence of):</p> <p>c. _____</p> <p>Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate interval Between Onset and Death</p> <p>Acute</p> <p>5 years</p> </div> </div> | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D14568 | | 29d. Date signed (Month, Day, Year) Oct. 19, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas E. Dooley, M.D. 17904 Georgia Avenue Olney, Maryland 20832 | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 3 1999 | | 32. Registrar's Signature  | | | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36232

| | | | | | | | | | | |
|---|---|--|--|--|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) FRANKLIN BUTLER | | | | | 2. Date of Death Month NOVEMBER Day 17 Year 1999 | | 3. Time of Death 00:48A | | |
| | 4a. Facility Name (If not institution, give street and number) SAINT AGNES HOSPITAL | | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 217-34.2305 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 59 Yrs. | | 8. Date of Birth (Month, Day, Year) 01-05-40 | | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 4016 WOODRIDGE ROAD | | | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 TH GRADE College (1-4 or 5+) N/A | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DRIVER | | | 16b. Kind of Business/Industry DISPOSAL | | | |
| | 17. Father's Name (First, Middle, Last) CHARLES DOVE | | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARY COLE | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) SHIRLEY BUTLER WIFE | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4016 WOODRIDGE ROAD, BALTO. MD. 21229 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK | | Date 11-20-99 | | 20c. Location - City or Town, State RANDALLSTOWN, MD | | |
| | 21. Signature of Funeral Service Licensee Vaughn C G | | | | | 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE, BALTO. MD. 21229 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Congestive Heart Failure Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | Approximate Interval Between Onset and Death minutes | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes End Stage Renal Disease | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> PER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier SC Attending Physician | | | | | 29c. License number 051853 | | 29d. Date signed (Month, Day, Year) November 17, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Silverman MD 900 Caton Avenue Baltimore 21229 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | | | | 32. Registrar's Signature Benjamin B. Sparks | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36233**
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Bess M. Bucci | | | | 2. Date of Death Month November Day 12 Year 1999 | | 3. Time of Death 8:15 PM. | |
| | 4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE Hospital Center | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 212-01-4313 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) 1/27/1919 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 8810 Walther Blvd. Apt 1222 | | 10f. Zip Code 21234 | | |
| 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | |
| 17. Father's Name (First, Middle, Last) Pasquale Pellegrini | | | | 18. Mother's Name (First, Middle, Maiden Surname) Giavanna DeBona | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Irid Naver/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Valley Wood Ct. Timonium, Maryland 21093 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Redeemer Cemetery | | Date 11/16/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 | | | | |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>e. Hemorrhagic Stroke</p> <p>Due to (or as a consequence of):</p> </div> <div> <p>Approximate Interval Between Onset and Death 10 hours</p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D45766 | | 29d. Date signed (Month, Day, Year) November 15, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tom Elmendorf MD, 9105 Franklin Square Dr, Ste 312, Baltimore, MD 21237 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | | | 32. Registrar's Signature | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36234
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHEA

2. Date of Death

Month Day Year
NOVEMBER 16 1999

3. Time of Death

1:30am

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSP OF MARYLAND

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

214-40-5504

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 20, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland

10b. County
Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

7525 Belair Rd.

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 yrs.

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Director

16b. Kind of Business/Industry

Balto. City Dept. of Recreation

17. Father's Name (First, Middle, Last)

George E. Bartens

18. Mother's Name (First, Middle, Maiden Surname)

Mary T. Connors

19a. Informant's Name/Relationship (Type, Print)

Gerard V. Caldwell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7701 Belair Rd. Baltimore, Md. 21236

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery 11-19-1999

Date

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LASSAHN FUNERAL HOME

7401 BELAIR RD. BALTIMORE, MD. 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

b. UROSEPSIS

Due to (or as a consequence of):

c. ARTEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

d. ALZHEIMERS DISEASE

Approximate Interval Between Onset and Death

3 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPOTHYROIDISM

NOTE INSULIN DEPENDENT DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicida 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Blay, MD

29c. License number

P1345

29d. Date signed (Month, Day, Year)

November 16 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BERTHA AYI, GOOD SAMARITAN HOSP OF MARYLAND, BALTIMORE, MD 21239

3601 LOTH RAVEN BLVD BALTIMORE, MD 21239

31. Date filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

James D. Sparks

State
Registrar

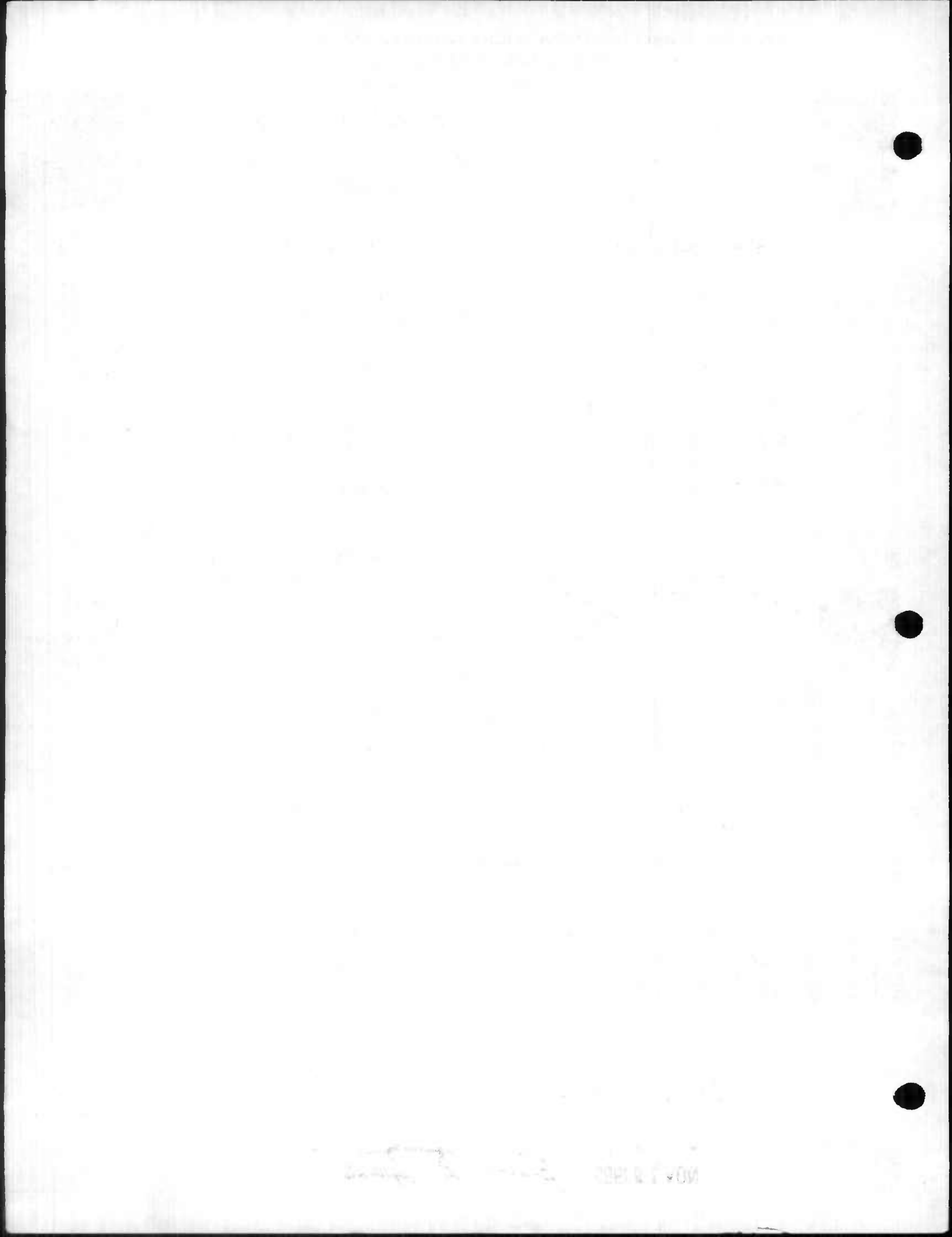
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36235**
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Miguel Berkovsky | | | | 2. Date of Death Month 11 Day 18 Year 99 | | 3. Time of Death 2240 | |
| | 4a. Facility Name (If not institution, give street and number) Mercy Medical Center | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 056 415 0217-3 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) MAR.10,1915 | |
| | 9. Birthplace (State or Foreign Country) RUSSIA | | 10a. State MEXICO | | 10b. County VERACRUZ | | 10c. City, Town or Location CORDOBA | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number CALLE 1 1515 | | 10f. Zip Code 94580 | | 10g. Citizen of What Country? MEXICO | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) ADMINISTRATOR | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | 16b. Kind of Business/Industry SUGAR FACTORY | | | | |
| 17. Father's Name (First, Middle, Last) ISAAC BERKOVSKY | | 18. Mother's Name (First, Middle, Maiden Surname) TAIBA KAGANOVICH | | 19a. Informant's Name/Relationship (Type, Print) SOLEDAD BERKOVSKY / WIFE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CALLE 1 1515 - CORDOBA, VERACRUZ, MEXICO 94580 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) OUT OF COUNTRY | | 20b. Place of Disposition (Name of cemetery, crematory or other place) DE MEXICO | | 20c. Location - City or Town, State MEXICO | | 21. Signature of Funeral Service Licensee Gaye Feldman | | |
| 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Mesenteric Ischemia Due to (or as a consequence of): b. Atrial Fibrillation Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death 2 days 9 years unknown | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. History Cerebral Vascular Accident | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 11/18/99 | | |
| 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Scott J. McPherson MD | | 29c. License number D0040166 | | 29d. Date signed (Month, Day, Year) 11/18/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scott J. McPherson MD | | 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature B. Spaul | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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ROBERT
COLE SR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36236

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Robert Meredith Cole, Sr. | | 2. Date of Death Month Day Year NOVEMBER 17, 1999 | | 3. Time of Death 11:01 PM. | |
| 4a. Facility Name (If not institution, give street and number) SHOCK TRAUMA | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death n/a | |
| 5. Social Security Number 219-28-0888 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 Yrs. | |
| 8. Date of Birth (Month, Day, Year) March 28, 1931 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location White Hall | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 18101 School House Rd. | | 10f. Zip Code 21161 | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: '56-'59 | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) n/a | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver | | 16b. Kind of Business/Industry Transportation | |
| 17. Father's Name (First, Middle, Last) Samuel Parkin Cole | | 18. Mother's Name (First, Middle, Maiden Surname) Ann Elizabeth Thacker | | | |
| 19a. Informant's Name/Relationship (Type, Print) Lois Cole/wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18101 School House Rd, White Hall, MD 21161 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Balto. Wash. Crematory | | 20c. Location - City or Town, State 11/22/99 Laurel, MD | |
| 21. Signature of Funeral Service Licensee Michael J. Flagle | | 22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Contact gunshot wound of head Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 11-17-99 | | 28b. Time of Injury unknown | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Subject shot self | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) 18101 School House Road Baltimore County, Maryland | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated. | | 29b. Signature and title of certifier Attyah A. Mackay, MD | | 29c. License number O.C.M.E. | |
| 29d. Data signed (Month, Day, Year) NOVEMBER 18, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature Bernie B. Sparks | | | |

ORIGINAL

W. H. H. H. H.

1904

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36237

| | | | | | | | | |
|--|---|---|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Aaron W. Crump | | | | 2. Date of Death Month Day Year November 14, 1999 | | 3. Time of Death 2:00 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) Bon Secours Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 213-86-5011 | | 6. Sex MM <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 31 Yrs. | | 8. Date of Birth (Month, Day, Year) 07 27 68 | |
| | 9. Birthplace (State or Foreign Country) M.D. | | 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) 10th grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance | | 16b. Kind of Business/Industry University of Balto | | 17. Father's Name (First, Middle, Last) Albert J. Crump Sr. | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Arlene Eubanks | | 19a. Informant's Name/Relationship (Type, Print) Albert Crump Sr.-Father | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3413 Croydon Road, Baltimore Md 21207 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park | | 20c. Location - City or Town, State 11/20/99 Randallstown, Md | | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) FOUND 11-4-99 | | |
| 28b. Time of Injury FOUND 1:15 | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred UNKNOWN | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) 900 BLK. ARLINGTON AVE BALTIMORE, CITY MD. | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) November 15, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner | | 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature | | 33. Date of filing (Month, Day, Year) NOV 19 1999 | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

99 36238

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Thomas Edward Comstock | | | | 2. Date of Death Month Day Year November 16 1999 | | | | 3. Time of Death 7:40 am | |
| | 4a. Facility Name (If not institution, give street and number) 940 Placid Court | | | | 4b. City, Town, or Location of Death Arnold | | | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 049-24-6660 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 65 Yrs. | | 8. Date of Birth (Month, Day, Year) March 22, 1934 | | 9. Birthplace (State or Foreign Country) Washington | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Arnold | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 940 Placid Court | | | | 10f. Zip Code 21012 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1951-55 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Analyst | | | | 16b. Kind of Business/Industry NSA | |
| | 17. Father's Name (First, Middle, Last) Elmer Edward Comstock | | | | 18. Mother's Name (First, Middle, Maiden Surname) Phyllis Baum | | | | | |
| To Be Completed by Funeral Director | 19a. Informant's Name/Relationship (Type, Print) Anita L. Comstock (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 940 Placid Court, Arnold, MD 21012 | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | 20c. Date 11/17 | | 20d. Location - City or Town, State Baltimore, MD | | | |
| | 21. Signature of Funeral Service Licensee <i>Michael P. Kutta</i> | | | | 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Carcinoma - Lung</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | 23b. Approximate Interval Between Onset and Death 1 1/2 yrs | | | | | | | | | |
| Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus</i> <i>Hypertension</i> <i>Hypertension</i> | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier <i>Joseph N. Friend</i> | | | | 29c. License number 017965 | | 29d. Date signed (Month, Day, Year) 11/16/99 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Joseph N. Friend 205 Ridgely Ave Annapolis, Md 21401</i> | | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature <i>Benjamin B. Sparks</i> | | | | | | | |

ORIGINAL

Handwritten signature

NOV 2 1958

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36239

| | | | | | | | | | | | |
|--|---|---|--|--|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edward A. Cichomski | | | | 2. Date of Death Month Day Year Nov. 15, 1999 | | 3. Time of Death 9:00 am | | | | |
| | 4a. Facility Name (If not institution, give street and number) 154 N. Potomac Street | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | | | |
| Funeral Director | 5. Social Security Number 215.01.1501 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 10, 1914 | | 9. Birthplace (State or Foreign Country) Poland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 154 N. Potomac Street | | | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? U.S.A. | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Merchant Seaman/Printer | | | 16b. Kind of Business/Industry U.S. Coast Guard | | | | |
| 17. Father's Name (First, Middle, Last) Ignanacy Cichomski | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Zawol | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Genevieve Jones/Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 154 N. Potomac St Baltimore, Md. 21224 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Stanislaus Cem. | | Date 11/18 | | 20c. Location - City or Town, State Baltimore, Md. | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Moran-Ashton-Dabrowski 3000 E. Baltimore St. Baltimore, Md. 21224 | | | | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Myocardial Infarction Due to (or as a consequence of): b. ARTERIO SCLEROTIC VASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death N/A Yr | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia, Hypertension Strokes, Heart Disease | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and Title of certifier  | | | | 29c. License number D24276 | | 29d. Date signed (Month, Day, Year) 11-15-99 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Simon Scalica 2801 Hudson St. 21224 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36240

| | | | | | | | | |
|---|--|--|--|---------------------------------------|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GENE M. CAMPBELL | | | | 2. Date of Death Month Day Year November 16, 1999 | | 3. Time of Death 7:23 AM | |
| | 4a. Facility Name (If not institution, give street and number) 18249 FALLS ROAD | | | | 4b. City, Town, or Location of Death HAMPSTEAD | | 4c. County of Death CARROLL | |
| Funeral Director | 5. Social Security Number 171-24-9388 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 70 Yrs. | | 8. Date of Birth (Month, Day, Year) 9/8/1929 | |
| | 10e. State Maryland | | 10b. County Carroll | | 10c. City, Town or Location Hampstead | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number 18249 Falls Road | | | | 10f. Zip Code 21074 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Representative | | 16b. Kind of Business/Industry Engineering | |
| | 17. Father's Name (First, Middle, Last) Tom Campbell | | | | 18. Mother's Name (First, Middle, Maiden Surname) Edna (Minton) | | | |
| | 19e. Informant's Name/Relationship (Type, Print) Rose Ann Campbell (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18249 Falls Rd. Hampstead MD 21074 | | | |
| | 20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery | | Date 11/22/99 | | 20c. Location - City or Town, State Garrison Forest MD | |
| | 21. Signature of Funeral Service Licensee K. Craig Witzke | | | | 22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville MD 21228 | | | |
| | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Alzheimer's Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Approximate Interval Between Onset and Death 6 years | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier David J. Loreck MD | | | | 29c. License number D37070 | | 29d. Date signed (Month, Day, Year) November 16, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David J. Loreck MD Balto VAMC 10W Greene St Balto MD 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | | | 32. Registrar's Signature B Sparks | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36241

| | | | | | | | | | | |
|---|---|--|---|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Madeline Marie Mills Dresser | | | | 2. Date of Death Month Day Year November 17 1999 | | | | 3. Time of Death 1900 | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 217-58-4243 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) May 8, 1920 | | 9. Birthplace (State or Foreign Country) Delaware | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Annapolis | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 1205 Tyler Avenue | | | | 10f. Zip Code 21403 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Alfred Heller | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Christine Jensen | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Nancy Owens (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3910 Old Birdsville Road, Harwood, MD 20776 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Cemetery | | Date 11/22 | | 20c. Location - City or Town, State Annapolis, MD | | | |
| | 21. Signature of Funeral Service Licensee <i>Michael P. Kutta</i> | | | | 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. hypoxia Due to (or as a consequence of): b. Acute respiratory failure Due to (or as a consequence of): c. Metastasis lungs bilateral Due to (or as a consequence of): d. Sarcoma, uterus | | | | | | | | Approximate Interval Between Onset and Death 8 hrs 2 days 3 wks 3 months | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Non insulin dependent Diabetes Chronic Atrial Fibrillation | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number 008314 | | 29d. Date signed (Month, Day, Year) 11/18/99 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GORDON C. SAMARINS MD 205 Ridgely Ave. - Annapolis, MD 21401 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) NOV 19 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | |

James A. Smith

NOV 18 1950

ADH

ANDY EADES G777 11-29-99 J.A.

99-6783-510 AMEND#16a&b,18 PER F.H.

AMEND#23a,27-28F PER M.E.O. G777 11-24-99 J.A.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36242

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|--|--|--|---|---|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Andy EADES | | | | 2. Date of Death Month Day Year NOVEMBER 12, 1999 | | | | 3. Time of Death 2010 PM | | | |
| | 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | | | 4c. County of Death | | | |
| Funeral Director | 5. Social Security Number 218-66-7033 | | 6. Sex 19 M 20 F | | 7. Age (In yrs. last birthday) 52 Yrs. | | 8. Date of Birth (Month, Day, Year) 10-27-47 | | 9. Birthplace (State or Foreign Country) Georgia | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits 1 Yes 2 No | | | |
| | 10e. Street and Number 1029 Wolfe Street | | | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? U.S.A. | | | | | |
| | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNK. | | | | 16b. Kind of Business/Industry UNK. | | | |
| | 17. Father's Name (First, Middle, Last) Louis Eades | | | | 18. Mother's Name (First, Middle, Maiden Surname) UNK. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Mary Hall - friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 524 Curly Street Balto., Md. | | | | | | | |
| | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Vashell Cemetery | | Date 11-19-99 | | 20c. Location - City or Town, State Balto., Md. | | | | | |
| | 21. Signature of Funeral Service Licensee Jeff Miller | | | | 22. Name and Address of Facility Jeff Miller P.F. Funeral Home & Services 1639 N. Broadway Balto., Md. 21213 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE ETHANOL AND NARCOTIC INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? partial 1 Yes 2 No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | |
| 25. Was case referred to medical examiner? XX Yes 20 No | | | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3X DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) FOUND 11-12-99 | | 28b. Time of Injury FOUND AT 7:35 PM | | 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred UNKNOWN | | |
| | | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6810 PARK HIGHTS AVENUE BALTIMORE, MARYLAND | | | | |
| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Dennis J. Chute MD | | | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) NOVEMBER 13, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | | | 32. Registrar's Signature [Signature] | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1001-1111

Handwritten signature

MOI 1800

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36243

| | | | | | | | | | | |
|---|--|---|--|---|--|---------------------------------|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Mildred Earehart</u> | | | | 2. Date of Death Month <u>11</u> Day <u>16</u> Year <u>99</u> | | | | 3. Time of Death <u>4:03 am</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>Mercy Medical Center 301 St. Paul St.</u> | | | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | | | 4c. County of Death <u>Baltimore City</u> | |
| Funeral Director | 5. Social Security Number <u>216-22-2611</u> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>70</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>Feb. 20, 1929</u> | | 9. Birthplace (State or Foreign Country) <u>Maryland</u> | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State <u>Maryland</u> | | 10b. County <u>Baltimore City</u> | | 10c. City, Town or Location <u>Baltimore</u> | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number <u>315 E. Fort Ave.</u> | | | | 10f. Zip Code <u>21230</u> | | | | 10g. Citizen of What Country? <u>United States</u> | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: <u>White</u> | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10</u> College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Nursing Assistant</u> | | | | 16b. Kind of Business/Industry <u>Nursing Home</u> | | |
| 17. Father's Name (First, Middle, Last) <u>Ollie Hood</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Mary Lowman</u> | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>Darlene Earehart/Daughter</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>315 E. Fort Ave., Baltimore, MD 21230</u> | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Metro Crematory, Inc. 1999</u> | | | | 20c. Location - City or Town, State <u>Catonsville, Maryland</u> | | |
| 21. Signature of Funeral Service Licensee <u>Paul L. Ebaugh</u> | | | | 22. Name and Address of Facility <u>Kirkley-Ruddick Funeral Home P.A.</u> <u>421 Crain Hwy. S.E. Glen Burnie, MD 21061</u> | | | | | | |
| 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>metastatic Colon Cancer</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death <u>6 mos.</u> | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension</u> | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <u>Signature MD</u> | | | | 29c. License number <u>D0053641</u> | | |
| 29d. Date signed (Month, Day, Year) <u>11-16-99</u> | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>Michelle Jubera MD 301 St. Paul St. Balto. MD 21202</u> | | | | | | |
| 31. Date filed (Month, Day, Year) <u>NOV 19 1999</u> | | | | 32. Registrar's Signature <u>Signature</u> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature

NOV 1 1955

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36244
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|--|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LEON FIELDS SR. | | | | 2. Date of Death Month Day Year NOV 16 th 1999 | | | | 3. Time of Death 5:45 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 213-09-9999 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 26, 1909 | | 9. Birthplace (State or Foreign Country) South Carolina | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 5504 The Alameda | | | | 10f. Zip Code 21239 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: African American | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Worker | | | | 16b. Kind of Business/Industry Private Companies | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) unk. | | | | 18. Mother's Name (First, Middle, Maiden Surname) unk. | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mr. Leon Fields Jr. (son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5504 The Alameda Balto. Md. 21239 | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Cem. 11/23/99 | | | | 20c. Location - City or Town, State Towson, Md. | | | |
| | 21. Signature of Funeral Service Licensee Joseph L. Russ | | | | 22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216 | | | | | |
| Physician /Medical Examiner | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION PNEUMONIA Due to (or as a consequence of): b. LARGE LEFT SIDED ISCHEMIC CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| | Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| State Registrar | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier Rosemarie Rampeasad M.D. | | | | 29c. License number P13457 | | | | 29d. Date signed (Month, Day, Year) NOV. 16 th 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROSEMARIE RAMPEASAD - MARAS 3601 LOCH RAVEN AVE GOOD SAMARITAN HOSPITAL BALT. MD 21239 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature [Signature] | | | | | | | | |

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NOA 1 1983

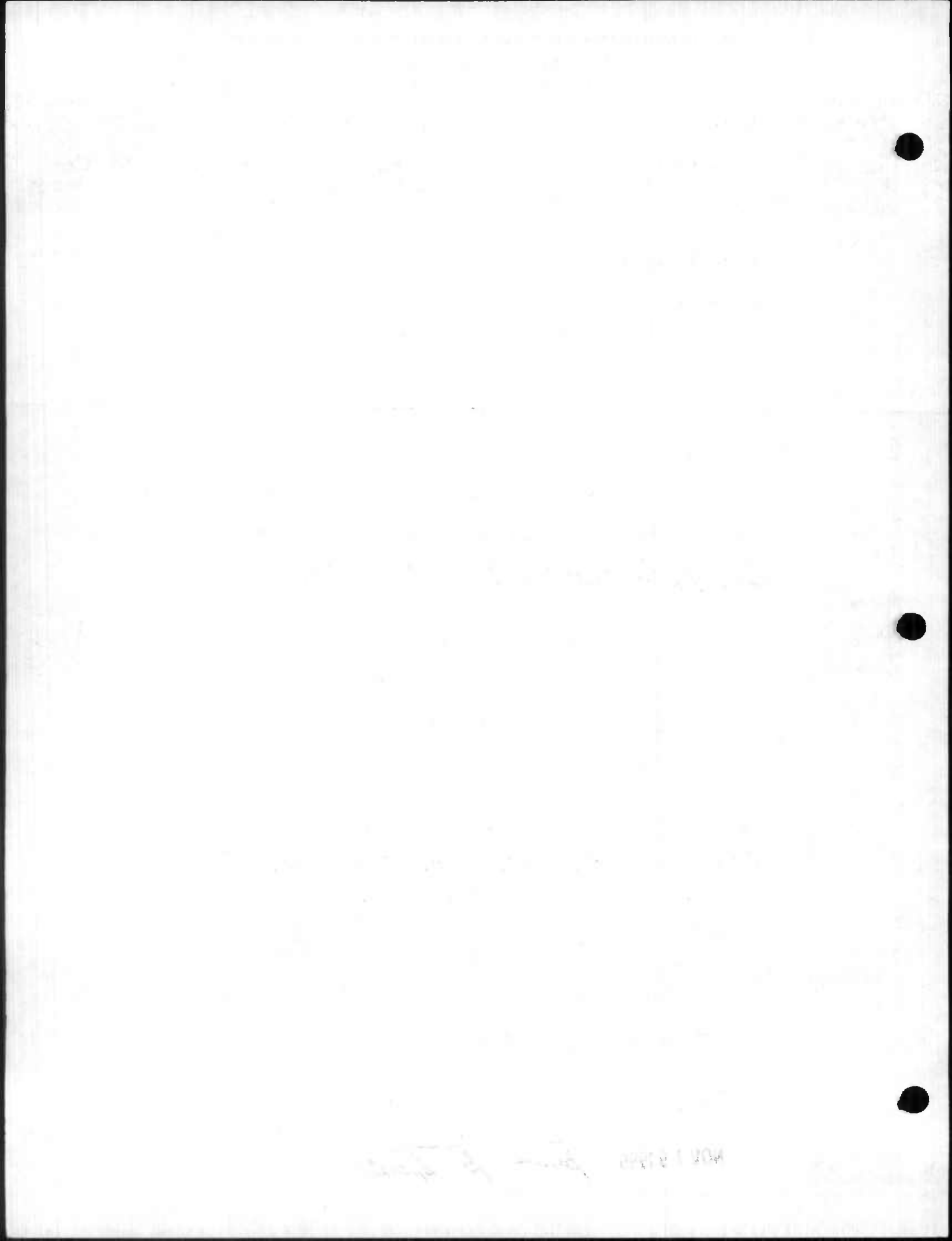
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36245

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|--------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WALTER FITCH | | 2. Date of Death Month November Day 14 Year 1999 5:05pm | | 3. Time of Death 5:05pm |
| | 4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSP OF MARYLAND | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE |
| Funeral Director | 5. Social Security Number 220-07-7050 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 83 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) June 19, 1916 | | 9. Birthplace (State or Foreign Country) Baltimore Co., MD. | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore |
| | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 4209 Mispillion Road | | |
| | 10f. Zip Code 21236 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 yrs. College (1-4 or 5+) n/a | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Superintendent | | 16b. Kind of Business/Industry Gen Star | | |
| | 17. Father's Name (First, Middle, Last) Harry A. Fitch | | 18. Mother's Name (First, Middle, Maiden Surname) Debora McLean | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mrs. Hazel M. Fitch (Wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4209 Mispillion Road Baltimore, MD. 21236 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Jarrettsville Cemetery | | 20c. Location - City or Town, State 11/18/99 Jarrettsville, MD. 21084 |
| | 21. Signature of Funeral Service Licensee E. F. Lassahn | | 22. Name and Address of Facility E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, MD. 21087 | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. INTRACEREBRAL BLEED Due to (or as a consequence of): b. HYPERTENSION Due to (or as a consequence of): c. PNEUMONIA Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death 130 DAYS |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CANCER OF THE PROSTATE CHRONIC RENAL INSUFFICIENCY CORONARY ARTERY DISEASE | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier Bayi, MD | | 29c. License number P1345 | | 29d. Date signed (Month, Day, Year) November, 14th, 1999 |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GOOD SAMARITAN HOSP OF MARYLAND INC, 5607 LOCH RAVEN BLVD, MD 21239 | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature Benjamin S. Sparks | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 10e per fh g777 11/23/99 ah

Certificate of Death

Reg. No.

99 36246

| | | | | | | | | |
|---|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ruth Wilcox Finlayson | | | | 2. Date of Death Month Day Year Nov 17 99 | | 3. Time of Death 12:35 am | |
| | 4a. Facility Name (If not institution, give street and number) Charlestown Care Center | | | | 4b. City, Town, or Location of Death Catonsville | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 215-10-8583 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 7, 1917 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Catonsville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 719 MAIDEN CHOICE LANE 5906 Edmondson Avenue BR332 | | 10f. Zip Code 21228 | |
| | 10g. Citizen of What Country? U.S.A. | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) I | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | | | 16b. Kind of Business/Industry American Trading Product | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Stuart R. Wilcox | | | | 18. Mother's Name (First, Middle, Maiden Surname) Emma A. Audoun | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Janice Hands (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1916 Clifden Road, Catonsville, MD 21228 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery | | 20c. Location - City or Town, State 11/20/99 Pikesville, Maryland | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebro Vascular Accident Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death Days | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier Andres Salazar MD | | | | 29c. License number D51051 | | 29d. Date signed (Month, Day, Year) November 18, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andres Salazar 711 Maidenchoice Lane, Catonsville, MD, 21228 | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year) NOV 19 1999 | | | | 32. Registrar's Signature [Signature] | | | |
| | 33. Registrar's Name [Signature] | | | | | | | |

ORIGINAL

[Handwritten signature]

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

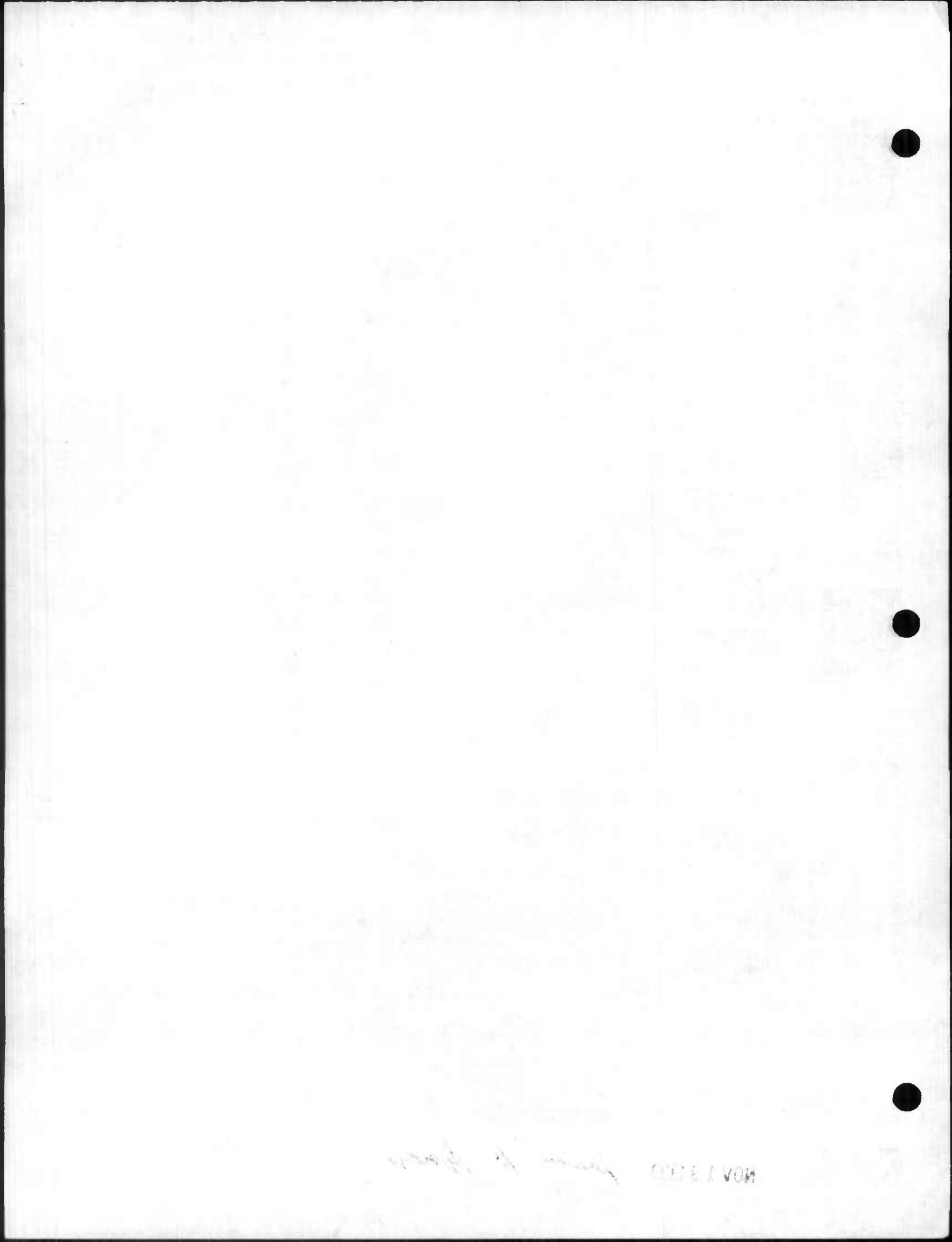
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36247

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Rose Giammona | | | | 2. Date of Death Month Day Year November 15, 1999 | | 3. Time of Death 10:40am | |
| | 4a. Facility Name (If not institution, give street and number) Stella Maris 2300 Dulaney Valley Rd. | | | | 4b. City, Town, or Location of Death n/a | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 220-48-5223 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 93 Yrs. | | 8. Date of Birth (Month, Day, Year) 12-8-1905 | |
| | 9. Birthplace (State or Foreign Country) Palermo, Sicily | | 10a. State MD | | 10b. County n/a | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 5424 Hilltop Avenue | | 10f. Zip Code 21206 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Wholesaler/Retailer | | 16b. Kind of Business/Industry Produce | | | |
| | 17. Father's Name (First, Middle, Last) Vincent Garofalo | | 18. Mother's Name (First, Middle, Maiden Surname) Cira Teresi | | 19a. Informant's Name/Relationship (Type, Print) daughter Shirley Iacoboni | | | |
| To Be Completed by Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2203 Fox Hunt Lane, Timonium, Maryland 21093 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Redeemer | | 20c. Location - City or Town, State Baltimore, Maryland | |
| | 21. Signature of Funeral Service Licensee Maria M. Zannino | | 22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Hm 263 S. Conkling St., Baltimore, Maryland 21224 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Congestive Heart Failure Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Depression Dementia | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier [Signature] | | 29c. License number 1053283 | | 29d. Date signed (Month, Day, Year) 11/16/99 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1477 South Hanover St Baltimore MD 21230 | | 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature [Signature] | | | |



MON 1 1904

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36248

| | | | | | | | | | |
|---|--|---|--|--|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>George W. Gilbert</i> | | | | 2. Date of Death Month <i>November</i> Day <i>17</i> Year <i>1999</i> | | 3. Time of Death <i>12:00 PM</i> | | |
| | 4a. Facility Name (If not institution, give street and number) <i>Franklin Woods Nursing Center</i> | | | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | 4c. County of Death <i>Baltimore</i> | | |
| Funeral Director | 5. Social Security Number <i>240-09-3206</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>85</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>Aug. 25, 1914</i> | | |
| | 9. Birthplace (State or Foreign Country) <i>N. Carolina</i> | | 10a. State <i>Maryland</i> | | 10b. County <i>N/A</i> | | 10c. City, Town or Location <i>Baltimore</i> | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number <i>4907 E. Chase Street</i> | | 10f. Zip Code <i>21205</i> | | 10g. Citizen of What Country? <i>U.S.A.</i> | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th Grade</i> | | College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Welder</i> | | 16b. Kind of Business/Industry <i>Manufacturing</i> | | | |
| 17. Father's Name (First, Middle, Last) <i>Henry Gilbert</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Nonie Strickland</i> | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Mrs. Judy M. Zuk (daughter)</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5 Lisa Ct., Baltimore, MD 21237</i> | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Bel Air Mem'l Gardens</i> | | Date <i>11/20/99</i> | | 20c. Location - City or Town, State <i>Bel Air, Maryland</i> | | | |
| 21. Signature of Funeral Service Licensee <i>Robert J. Dodack, Jr.</i> | | | | 22. Name and Address of Facility <i>Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236</i> | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. CORD</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death <i>10 yrs</i> | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cerebrovascular Accident</i> <i>Colon Cancer</i> <i>Atherosclerosis</i> | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and Title of Certifier <i>[Signature]</i> | | 29c. License number <i>031076</i> | | 29d. Date signed (Month, Day, Year) <i>11/17/99</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Oliver E. Wastan M.D., 6830 Hospital Dr., Baltimore, Md 21237</i> | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>NOV 19 1999</i> | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36249

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LIMMIE GOODMAN

2. Date of Death

11-14-99

Day

Year

3. Time of Death

2:35 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

ROCK GLEN NURSING HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

263-10-3634

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

01-08-18

9. Birthplace (State or Foreign Country)

FL

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

523 LYNHURST STREET

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6TH GRADE

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CUSTODIAN

16b. Kind of Business/Industry

CITY OF BALTIMORE

17. Father's Name (First, Middle, Last)

LIMMIE GOODMAN, SR.

18. Mother's Name (First, Middle, Maiden Surname)

DARNELLER LEWIS

19a. Informant's Name/Relationship (Type, Print)

DERRICK GOODMAN / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

523 LYNHURST ST., BALTO. MD. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUTUS CEMETERY

Date

11-19-99

20c. Location - City or Town, State

BALTO. MD

21. Signature of Funeral Service Licensee

Vaughn C. Greene

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO. NAT'L PIKE, BALTO. MD. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. END STAGE RENAL DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 YEAR.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. HYPERTENSIVE CARDIOVASCULAR DISEASE UNKNOWN

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ADVANCED DEMENTIA.

STROKES - MULTIPLE.

BILATERAL PNEUMONIA.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kamal K. Dang

29c. License number

D18362

29d. Date signed (Month, Day, Year)

11-15-1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

KOMAL K. DANG M.D., 3455 Wilkens Ave, Suite 308, Balto. Md 21229.

State
Registrar

31. Date filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

Kamal K. Dang

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36250

| | | | | | | | | | | | |
|---|--|---|--|---|--|---------------------------------|--|---|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Zenobia Gardner | | | | 2. Date of Death Month November Day 18 Year 1999 | | | | 3. Time of Death 7:18 AM | | |
| | 4a. Facility Name (If not institution, give street and number) Maryland General Hospital | | | | 4b. City, Town, or Location of Death Baltimore City | | | | 4c. County of Death | | |
| Funeral Director | 5. Social Security Number 230-12-5266 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) 04 06 24 | | 9. Birthplace (State or Foreign Country) M.D. | | |
| | Usual Residence of Decedent | | | | 10a. State MD | | | | 10b. County NA | | 10c. City, Town or Location Baltimore |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 4017 Liberty Heights Ave | | | | 10f. Zip Code 21207 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) na | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A | | | | 16b. Kind of Business/Industry N/A | | | |
| 17. Father's Name (First, Middle, Last) Frank Carter | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sadie Lancaster | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Maria Beane-Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4212 Ridgewood Ave, Baltimore Md 21215 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Park | | | | 20c. Location - City or Town, State 11/22/99 Arbutus, Md | | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 | | | | | | | |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia Due to (or as a consequence of): Respiratory Failure Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier <i>[Signature]</i> MD | | | | 29c. License number 89356 | | 29d. Date signed (Month, Day, Year) 11/18/99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Haider Sarraf, M.D. to Maryland General Hospital | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Maria Beane-Sister

4212 Ridgewood Ave, Baltimore Md 21215

XX

Arbutus Mem. Park

11\22\99 Arbutus, Md

March F/H West

4300 Wabash Ave, Baltimore Md 21215

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36251

| | | | | | | | | |
|---|--|--|---|--|---|--|-------------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Catherine Ann George | | | | 2. Date of Death Month Day Year NOV. 16, 1999 | | 3. Time of Death 2149 PM | |
| | 4a. Facility Name (If not institution, give street and number) MUDDY CREEK ROAD | | | | 4b. City, Town, or Location of Death EDGEWATER | | 4c. County of Death ANNE ARUNDEL | |
| Funeral Director | 5. Social Security Number 220-13-6580 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 20 Yrs. | 8. Date of Birth (Month, Day, Year) July 27, 1979 | 9. Birthplace (State or Foreign Country) Texas | | | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Annapolis | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number 952 Aqua Court | | | | 10f. Zip Code 21401-4743 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Amerasian | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bank Teller | | 16b. Kind of Business/Industry Banking | | |
| 17. Father's Name (First, Middle, Last) Charles Ross George, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Engelberta Escolor Genonsalao | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Charles R. George, Sr. (Father) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 952 Aqua Court, Annapolis, MD 21401-4743 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. James Cemetery | | Date 11/20 | | 20c. Location - City or Town, State Lothian, Maryland | | |
| 21. Signature of Funeral Service Licensee Michelle P. Litta | | | | 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 11/16/99 | | 28b. Time of Injury 2194 M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred Driver of motor vehicle collides with another vehicle | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street; Muddy Creek Road; Edgewater, Md. | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Joseph Pestaner, M.D. | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) NOV. 17, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature Benjamin B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten signature

BBB 1 VOM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36252**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH A. GREGOIRE

2. Date of Death

Nov. 14, 1999

3. Time of Death

6:30 pm

4a. Facility Name (If not institution, give street and number)

Future Care

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219.20.8031

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 16, 1913

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

123 West 29th Street Apt. 7H

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Personnel Clerk

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

Egbert A. Pitkin

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Jennings

19a. Informant's Name/Relationship (Type, Print)

Michael Athey/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

123 West 29th Street Apt. 7H Baltimore, MD 21218

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE WASHINGTON CREMATORY

20c. Location - City or Town, State

LAUREL, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

BRADLEY-ASHTON-MATTHEWS FUNERAL HOMES, INC.

2134 WILLOW SPRING ROAD DUNDALK, MARYLAND 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic obstructive Pulmonary disease

Due to (or as a consequence of):

b. Coronary Artery disease

Due to (or as a consequence of):

c. Cerebrovascular disease

Due to (or as a consequence of):

d. Degenerative Joint Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 31464

29d. Date signed (Month, Day, Year)

11/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHOAH A. HASHTMI, 821 N. Eutaw St Suite 308, Balt. MD 21201

31. Date filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36253

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Audrey Theresa Holthause

2. Date of Death

Month Day Year
Nov. 19 1999

3. Time of Death

4:35 AM

4a. Facility Name (If not institution, give street and number)

6111 Rollingview Drive

4b. City, Town, or Location of Death

Eldersburg

4c. County of Death

Carroll

5. Social Security Number

213-28-0444

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 7, 1932

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Eldersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6111 Rollingview Drive

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Corporate Secretary

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

John W. Sturm, Jr.

18. Mother's Name (First, Middle, Maiden Summa)

Sophie Watroba

19a. Informant's Name/Relationship (Type, Print)

John R. Holthause, III

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6111 Rollingview Dr., Eldersburg, MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Jessops United Meth.Ch.Cem. 11/22/99

20c. Location - City or Town, State

Sparks, MD

21. Signature of Funeral Service Licensee

Lower M. Lemmon

22. Name and Address of Facility

Lemmon Funeral Home
10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Liver Metastases / Liver failure

Due to (or as a consequence of):

b. Pancreatic Cancer

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

4 mo

4 mo

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Wm C Waterfield MD

29c. License number

024356

29d. Date signed (Month, Day, Year)

Nov 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wm C Waterfield MD 900 Calverton Rd Baltimore MD 21229

31. Date filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

B Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

ST. LOUIS, MO.

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ST. LOUIS, MO.

1902

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ST. LOUIS, MO.

RECEIVED

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36254

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clyde Hicks

2. Date of Death

Month Day Year
NOVEMBER 9, 1999

3. Time of Death

3:12 PM

4a. Facility Name (If not institution, give street and number)

Doctors Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George

Funeral
Director

5. Social Security Number

261-78-6043

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 10, 1908

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6931 Heidelberg Road

10f. Zip Code

20706

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Hampton Cecil Smith

18. Mother's Name (First, Middle, Maiden Surname)

Rebecca Mae Davis

19a. Informant's Name/Relationship (Type, Print)

Betty Ricketson/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6931 Heidelberg Road, Lanham, Maryland 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Peoria Cemetery

Date

11/15/99 Orange Park, Florida

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Hyperglycemic coma*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Extensive pneumonia*
Due to (or as a consequence of):
c. *Alzheimer's disease*
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

D13339

29d. Date signed (Month, Day, Year)

11/9/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TSUN-IE CHAN CHIEV 8824 Cunningham Drive Berwyn Heights

State
Registrar

31. Data filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

[Signature]

ORIGINAL

CLYDE HICKS

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

[Handwritten signature]

MOA 1 8 1988

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36255

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sharon Cameron Provan Harris

2. Date of Death

November 11 1999

3. Time of Death

9:48 am

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

224-54-4723

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Dec. 9, 1941

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Edgewater

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

532 Highland Drive

10f. Zip Code

21037

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Electrician Apprentice

16b. Kind of Business/Industry

Electrical

17. Father's Name (First, Middle, Last)

James Byron Provan

18. Mother's Name (First, Middle, Maiden Summa)

Nina Vivian Taylor

19a. Informant's Name/Relationship (Type, Print)

Nina V. Taylor Elmer (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

532 Highland Drive, Edgewater, MD 21037

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mayo U.M. Cemetery

Date

11/15

20c. Location - City or Town, State

Edgewater, MD

21. Signature of Funeral Service Licensee

Michael P. Latta

22. Name and Address of Facility

Hardesty Funeral Home, P.A.
12 Ridgely Avenue, Annapolis, MD 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Diabetes Mellitus

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

8 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
end manner stated.

29b. Signature and title of certifier

Michael P. Latta MD

29c. License number

D31775

29d. Date signed (Month, Day, Year)

November 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2003 Medical Parkway Ste. 100 Annapolis, MD 21401

31. Date filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

Jennifer B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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within 24 hours after death.
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completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Handwritten text in the upper middle section, possibly a title or header.

Handwritten text in the middle right section.

Handwritten text in the lower middle section, possibly a signature or date.

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|--|---|---|---|---|--------------------------------------|--|--|---|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Pierce Jackson Hancock, Jr | | | | 2. Date of Death Month Day Year NOVEMBER 14, 1999 | | 3. Time of Death 1348 PM | | | | |
| | 4a. Facility Name (If not institution, give street and number) MARYLAND GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death | | | | |
| Funeral Director | 5. Social Security Number 252 86 5840 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 49 Yrs. | | 8. Date of Birth (Month, Day, Year) 04 22 1950 | | 9. Birthplace (State or Foreign Country) Atlanta, GA | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State GA | | 10b. County Hall | | 10c. City, Town or Location Gainesville | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10a. Street and Number 4701 Shirley Rd. | | | | 10f. Zip Code 30506 | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Rare Coin Collector | | | 16b. Kind of Business/Industry Self Employed | | | | |
| 17. Father's Name (First, Middle, Last) Pierce J. Hancock, SR. | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Smith | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Pierce j. Hancock, SR./Dad | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1630 Walker St. Gainesville, GA 30501 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Alta Vista Cemetery | | Date 11/18/99 | | 20c. Location - City or Town, State Gainesville, GA | | | |
| 21. Signature of Funeral Service Licensee Mgt. Marshall | | | | | 22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home Inc. 736 Edmondson Ave. Catonsville, MD 21228 | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive and atherosclerotic b. Cardiovascular Disease c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier J. P. Putterman, M.D. | | | | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) NOVEMBER 15, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestano, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date died (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature Benita B. Sparks | | | | | | | | | |

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36257

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|-------------------------------|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Robert HUNTER | | | | 2. Date of Death Month Day Year November 15 1999 | | 3. Time of Death 14:34 | |
| | 4a. Facility Name (If not institution, give street and number) Ben Sicaours Hosp. 2000 W. Baltimore St Baltimore | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 250186933 | | 6. Sex 15 M 2 F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) 05-10-1919 | |
| | 9. Birthplace (State or Foreign Country) South Carolina | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits 1 X Yes 2 No | | 10e. Street and Number 1004 McKean Avenue | | 10f. Zip Code 21217 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 X Never Married 2 Married 3 X Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter | | 16b. Kind of Business/Industry Self Employed | | 17. Father's Name (First, Middle, Last) Robert Hunter | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Wm | | 19a. Informant's Name/Relationship (Type, Print) Josephine Jupiter - Sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1004 McKean Avenue; Baltimore, Maryland 21217 | | 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) National Cemetery | | 20c. Location - City or Town, State 11/19/99 Florence, South Carolina | | 21. Signature of Funeral Service Licensee [Signature] | | 22. Name and Address of Facility Sterling-Ashton Funeral Home, Inc. 736 Edmondson Avenue, Catonsville, MD. 21228 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. metastatic cancer of the prostate Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | 24a. Was an autopsy performed? 1 Yes 2 X No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | |
| 25. Was case referred to medical examiner? 1 Yes 2 X No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 X DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | 27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | |
| 29b. Signature and title of certifier [Signature] MD | | 29c. License number D47322 | | 29d. Date signed (Month, Day, Year) 11/15/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hm Teague 2000 W. Balt St Balt MD 21223 | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature [Signature] | | 33. State Registrar | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | |

ORIGINAL

WOM 1 1932

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36258

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|---------------------------|---|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Lelia C. Johnson</u> | | | | 2. Date of Death Month <u>November</u> Day <u>15</u> Year <u>1999</u> | | 3. Time of Death <u>2:25 PM</u> | | |
| | 4a. Facility Name (If not institution, give street and number) <u>Union Memorial Hospital Baltimore</u> | | | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | 4c. County of Death <u>N/A</u> | | |
| Funeral Director | 5. Social Security Number <u>218-28-8483</u> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <u>69</u> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <u>July 12, 1930</u> | 9. Birthplace (State or Foreign Country) <u>Maryland</u> | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State <u>Maryland</u> | | 10b. County <u>N/A</u> | | 10c. City, Town or Location <u>Baltimore</u> | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number <u>6147 Macbeth Drive</u> | | | | 10f. Zip Code <u>21239</u> | | 10g. Citizen of What Country? <u>USA</u> | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>Black</u> | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+) <u>2</u> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>LPN</u> | | 16b. Kind of Business/Industry <u>Private Duty</u> | | | |
| 17. Father's Name (First, Middle, Last) <u>Thomas R. Brown</u> | | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Geraldine Waters</u> | | | | |
| 19a. Informant's Name/Relationship (Type, Print) (sister) <u>Ms. Martha A. Brown</u> | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1500 Ramblewood Rd. Balto. Md. 21239</u> | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>King Memorial Park</u> | | Date <u>11/22/99</u> | | 20c. Location - City or Town, State <u>Balto. Md.</u> | | |
| 21. Signature of Funeral Service Licensee <u>Joseph L. Russ</u> | | | | | 22. Name and Address of Facility <u>Joseph L. Russ Funeral Home</u> <u>2222 W. North Ave. Balto. Md. 21216</u> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Myocardial Infarction</u> Due to (or as a consequence of): b. <u>Coronary Artery Disease</u> Due to (or as a consequence of): c. <u>Diabetes</u> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death <u>10 minutes</u> <u>20 yrs</u> <u>30 yrs</u> | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic Obstructive Pulmonary Disease</u> | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier <u>[Signature]</u> MD | | | | | 29c. License number <u>D33330</u> | | 29d. Date signed (Month, Day, Year) <u>November 15th 1999</u> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>John Earl Stokes Jr MD</u> | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <u>NOV 19 1999</u> | | | 32. Registrar's Signature <u>[Signature]</u> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36259

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Nelson Kearney, Sr.

2. Date of Death

Month

Day

Year

November 16, 1999

3. Time of Death

4:20 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

BALTIMORE

5. Social Security Number

213-20-7094

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

July 2, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Perry Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8623 Silver Lake Drive

10f. Zip Code

21128

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8th Grade

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Contractor

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Maurice Kearney

18. Mother's Name (First, Middle, Maiden Summa)

Katherine Powers

19a. Informant's Name/Relationship (Type, Print)

Edward N. Kearney, Jr. (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8621 Silver Lake Dr., Perry Hall, MD 21128

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem.

Date

11/20/99 Baltimore, Maryland

21. Signature of Funeral Service Licensee

Robert J. Goddard, Jr.

22. Name and Address of Facility

Schimunek Funeral Home, Inc.
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Wegener's GRANULOMATOSIS

Due to (or as a consequence of):

2 weeks

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Chardon, MD

29c. License number

RD 191775

29d. Date signed (Month, Day, Year)

11/16/99

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

DR. MADAI CHARDON 9000 FRANKLIN SQUARE DR. BALTIMORE, MARYLAND 21237

31. Date filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

[Signature]

State
Registrar

NOV 19 1963

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36260

Amended Item 23A PTII per PhyG777 11/19/99 EW

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Constance R. Lloyd

2. Date of Death
Month Day Year
Nov. 3, 19993. Time of Death
12:27pm

4a. Facility Name (If not institution, give street and number)

William Hill Manor

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

057-07-0969

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

May 30, 1902

9. Birthplace (State or Foreign Country)

R.I.

Usual Residence of Decedent

10a. State

MD

10b. County

Talbot

10c. City, Town or Location

Easton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

501 Dutchman's Lane

10f. Zip Code

21601

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Retail Sales

17. Father's Name (First, Middle, Last)

Charles Matlack

18. Mother's Name (First, Middle, Maiden Surname)

Mary Fletcher Stevens

19a. Informant's Name/Relationship (Type, Print)

Joanna Garbisch/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 368, St. Michael's, MD 21663

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street, Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. *Immunization*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *starvation*
Due to (or as a consequence of):c. *Esophageal Swallowing Disorder*
Due to (or as a consequence of):

4ms

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Unhealed Fracture @ Tibial Plateau**ASHD with Coronary Artery Disease*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William H. Wood J MD

29c. License number

D08715

29d. Date signed (Month, Day, Year)

11/3/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William H. Wood, 501 Dutchman's Lane, Easton, MD

31. Date filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

Benjamin B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

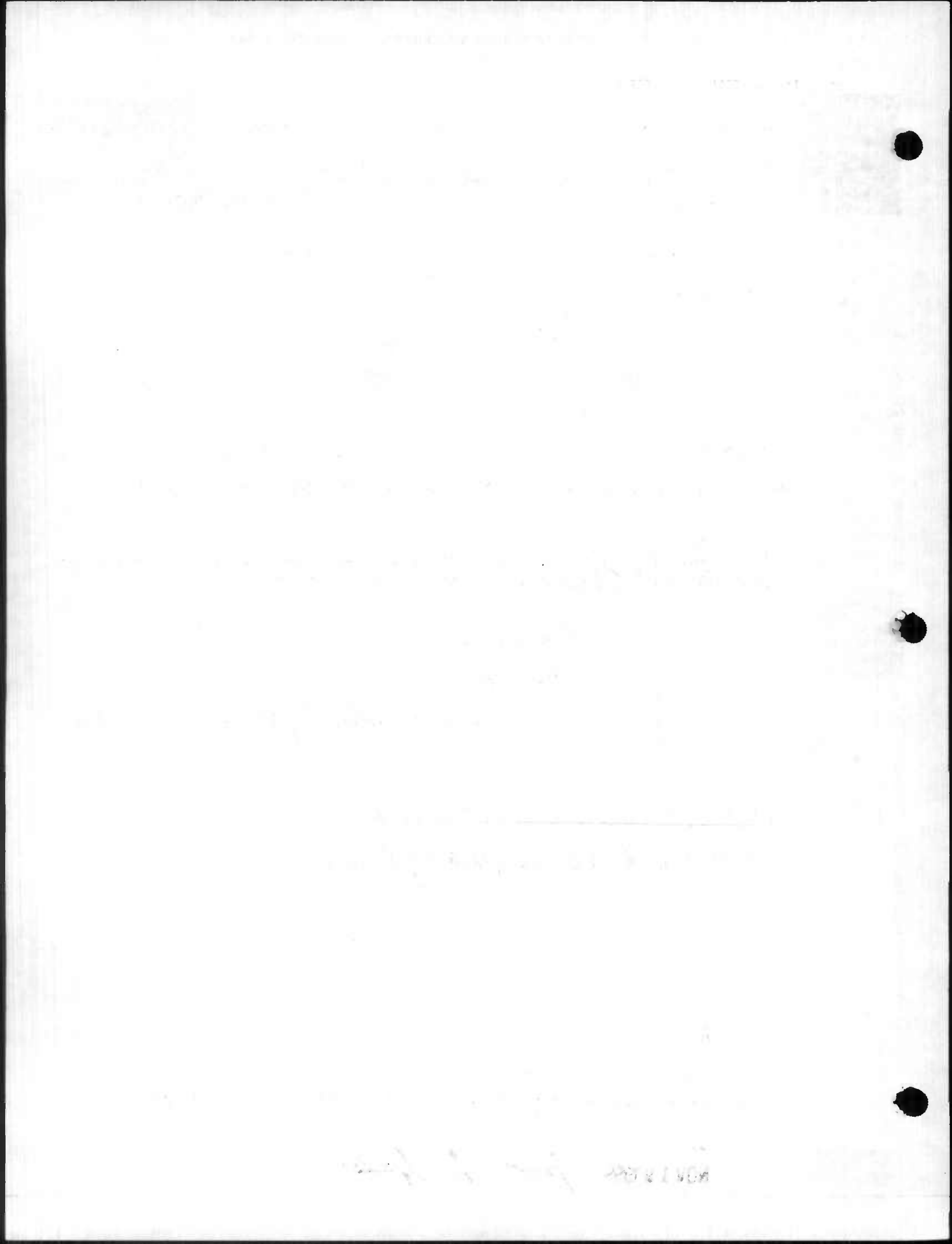
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36261

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Wallace C. Long | | | | 2. Date of Death Month Day Year November 14, 1999 | | 3. Time of Death 4:25 p.m. | |
| | 4a. Facility Name (If not institution, give street and number) Lorien Nursing Home | | | | 4b. City, Town, or Location of Death Columbia | | 4c. County of Death Howard | |
| Funeral Director | 5. Social Security Number 577-07-8684 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 99 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 5, 1900 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Howard | | 10c. City, Town or Location Columbia | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State MD | | | 10b. County Howard | | | 10c. City, Town or Location Columbia | | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 10e. Street and Number 6500 Freetown Road #314 | | | 10f. Zip Code 21044 | | |
| 10g. Citizen of What Country? USA | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 0 | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Shipping Clerk | | | 16b. Kind of Business/Industry AT & T | | | 17. Father's Name (First, Middle, Last) Oliver Clay Long | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Rebecca Hardtdraf | | | 19a. Informant's Name/Relationship (Type, Print) Emma H. Long/Wife | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6500 Freetown Road #314, Columbia, Maryland 21044 | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Washington Cr. 11/18 | | | 20c. Location - City or Town, State Laurel, Maryland | | |
| 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Recurrent Aortic Aneurysm Due to (or as a consequence of): Drip b. Cerebral Vasculature Disease Due to (or as a consequence of): wks c. Coronary Artery Disease Due to (or as a consequence of): wks - yrs d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | 29c. License number D-34868 | | | 29d. Date signed (Month, Day, Year) Nov 18, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dorian 11055 Little Pasture Rd Columbia, MD 21044 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | | 32. Registrar's Signature | | | | | |

ORIGINAL

Handwritten signature

Nov 1 1955

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36262

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John Anthony Miller Jr. | | | | 2. Date of Death Month Day Year NOVEMBER 17, 1999 | | 3. Time of Death 3:00 PM | |
| | 4e. Facility Name (If not institution, give street and number) Saint Joseph Medical Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 218-28-9931 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 66 Yrs. | | 8. Date of Birth (Month, Day, Year) 02/ 03/ 1933 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Harford | | 10c. City, Town or Location Bel Air | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 1414 Redfield Rd. | | 10f. Zip Code 21015 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korean | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor | | 16b. Kind of Business/Industry Engineering | | | | |
| 17. Father's Name (First, Middle, Last) John Anthony Miller Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Haslbeck | | | | |
| 19e. Informant's Name/Relationship (Type, Print) Regina W. Miller/ Spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1414 Redfield Rd. Bel Air, Maryland 21015 | | | | |
| 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gardens 11/22 Timonium Maryland | | 20c. Location - City or Town, State | | | | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester St. Baltimore Maryland 21231 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ISCHEMIC CARDIOMYOPATHY Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. TYPE II DIABETES MELLITUS | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Natividad D. de Leon, M.D. | | 29c. License number D19508 | | 29d. Date signed (Month, Day, Year) Nov. 17, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIVIDAD D. DELEON M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 | | 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature | | | | |

NOV 1 1964

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36263**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Marie McKeldin | | | | 2. Date of Death Month Nov. Day 17 Year 1999 | | 3. Time of Death 7:15A.M. | |
| 4a. Facility Name (If not institution, give street and number) Ridgeway Manor Nursing Home | | | | 4b. City, Town, or Location of Death Baltimore County | | 4c. County of Death Baltimore | |
| 5. Social Security Number 216-07-3174 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 88 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 6. Date of Birth (Month, Day, Year) Oct. 18, 1911 | |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore City | | 10c. City, Town or Location Baltimore City | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 4208 Kenwood Avenue | | | | 10f. Zip Code 21206 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary/Supervisor | | 16b. Kind of Business/Industry Bendix Company | |
| 17. Father's Name (First, Middle, Last) William Segrist | | | | 18. Mother's Name (First, Middle, Maiden Surname) Barbara Klecka | | | |
| 19a. Informant's Name/Relationship (Type, Print) James A. Segrist | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 134 Lyndale Avenue Baltimore, Md. 21236 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cemetery | | Date 11-20-99 | | 20c. Location - City or Town, State Baltimore, Maryland | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland 21236 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardio-pulmonary arrest Due to (or as a consequence of): ASCVD Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last COPD Due to (or as a consequence of): Approximate Interval Between Onset and Death | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier guyoso, M.D. | | | | | |
| | | 29c. License number 12-19528 | | 29d. Date signed (Month, Day, Year) 11/17/99 | | | |
| 30. Name and address of person who completed cause of death (Item 22a) (Type, Print) ELMO M. GUYOSO 5411 Old Frederick Road | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36264

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) William Menn | | | | 2. Date of Death Month Day Year NOVEMBER 17, 1999 | | 3. Time of Death 04:05 PM | |
| | 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 219-01-1650 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 91 Yrs. | | 8. Date of Birth (Month, Day, Year) July 14, 1908 | |
| | 9. Birthplace (State or Foreign Country) Germany | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Halethorpe | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 1726 Winans Avenue | | 10f. Zip Code 21227 | | |
| 10g. Citizen of What Country? United States | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baker | | 16b. Kind of Business/Industry Bakery | | |
| 17. Father's Name (First, Middle, Last) Williams Louis Menn | | | | 18. Mother's Name (First, Middle, Maiden Surname) Wilhelmina Paulina Figge | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Maxine M. Menn (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1726 Winans Avenue Halethorpe, MD 21227 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park | | 20c. Location - City or Town, State 11/20/99 Dorsey, MD | | 20d. Date | | |
| 21. Signature of Funeral Service Licensee Sharon M. M. Gangle | | 22. Name and Address of Facility Ambrose Funeral Home 1328 Sulphur Spring Road Arbutus, MD 21227 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ENCEPHALOPATHY | | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE CORONARY ARTERY DISEASE | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 23d. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 23e. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24c. Describe how injury occurred | | |
| 24d. Location (Street and Number or Rural Route Number, City or Town, State) | | 24e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 24f. Date of Injury (Month, Day, Year) | | 24g. Time of Injury M | | |
| 24h. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24i. Date of Injury (Month, Day, Year) | | 24j. Time of Injury M | | 24k. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24l. Date of Injury (Month, Day, Year) | | 24m. Time of Injury M | | 24n. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24o. Date of Injury (Month, Day, Year) | | |
| 24p. Time of Injury M | | 24q. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24r. Date of Injury (Month, Day, Year) | | 24s. Time of Injury M | | |
| 24t. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24u. Date of Injury (Month, Day, Year) | | 24v. Time of Injury M | | 24w. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24x. Date of Injury (Month, Day, Year) | | 24y. Time of Injury M | | 24z. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24aa. Date of Injury (Month, Day, Year) | | |
| 24ab. Time of Injury M | | 24ac. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24ad. Date of Injury (Month, Day, Year) | | 24ae. Time of Injury M | | |
| 24af. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24ag. Date of Injury (Month, Day, Year) | | 24ah. Time of Injury M | | 24ai. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24aj. Date of Injury (Month, Day, Year) | | 24ak. Time of Injury M | | 24al. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24am. Date of Injury (Month, Day, Year) | | |
| 24an. Time of Injury M | | 24ao. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24ap. Date of Injury (Month, Day, Year) | | 24aq. Time of Injury M | | |
| 24ar. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24as. Date of Injury (Month, Day, Year) | | 24at. Time of Injury M | | 24au. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24av. Date of Injury (Month, Day, Year) | | 24aw. Time of Injury M | | 24ax. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24ay. Date of Injury (Month, Day, Year) | | |
| 24az. Time of Injury M | | 24ba. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24bb. Date of Injury (Month, Day, Year) | | 24bc. Time of Injury M | | |
| 24bd. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24be. Date of Injury (Month, Day, Year) | | 24bf. Time of Injury M | | 24bg. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24bh. Date of Injury (Month, Day, Year) | | 24bi. Time of Injury M | | 24bj. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24bk. Date of Injury (Month, Day, Year) | | |
| 24bl. Time of Injury M | | 24bm. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24bn. Date of Injury (Month, Day, Year) | | 24bo. Time of Injury M | | |
| 24bp. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24bq. Date of Injury (Month, Day, Year) | | 24br. Time of Injury M | | 24bs. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24bt. Date of Injury (Month, Day, Year) | | 24bu. Time of Injury M | | 24bv. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24bw. Date of Injury (Month, Day, Year) | | |
| 24bx. Time of Injury M | | 24by. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24bz. Date of Injury (Month, Day, Year) | | 24ca. Time of Injury M | | |
| 24cb. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24cc. Date of Injury (Month, Day, Year) | | 24cd. Time of Injury M | | 24ce. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24cf. Date of Injury (Month, Day, Year) | | 24cg. Time of Injury M | | 24ch. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24ci. Date of Injury (Month, Day, Year) | | |
| 24cj. Time of Injury M | | 24ck. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24cl. Date of Injury (Month, Day, Year) | | 24cm. Time of Injury M | | |
| 24cn. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24co. Date of Injury (Month, Day, Year) | | 24cp. Time of Injury M | | 24cq. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24cr. Date of Injury (Month, Day, Year) | | 24cs. Time of Injury M | | 24ct. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24cu. Date of Injury (Month, Day, Year) | | |
| 24cv. Time of Injury M | | 24cw. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24cx. Date of Injury (Month, Day, Year) | | 24cy. Time of Injury M | | |
| 24cz. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24da. Date of Injury (Month, Day, Year) | | 24db. Time of Injury M | | 24dc. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24de. Date of Injury (Month, Day, Year) | | 24dd. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | |
| 24dg. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24dg. Time of Injury M | | |
| 24dh. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24dh. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24di. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24di. Date of Injury (Month, Day, Year) | | |
| 24dj. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24dj. Time of Injury M | | |
| 24dk. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24dk. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24dl. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24dl. Date of Injury (Month, Day, Year) | | |
| 24dm. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24dm. Time of Injury M | | |
| 24dn. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24dn. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24do. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24do. Date of Injury (Month, Day, Year) | | |
| 24dp. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24dp. Time of Injury M | | |
| 24dq. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24dq. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24dr. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24dr. Date of Injury (Month, Day, Year) | | |
| 24ds. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24ds. Time of Injury M | | |
| 24dt. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24dt. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24du. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24du. Date of Injury (Month, Day, Year) | | |
| 24dv. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24dv. Time of Injury M | | |
| 24dw. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24dw. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24dx. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24dx. Date of Injury (Month, Day, Year) | | |
| 24dy. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24dy. Time of Injury M | | |
| 24dz. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24dz. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24ea. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24ea. Date of Injury (Month, Day, Year) | | |
| 24eb. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24eb. Time of Injury M | | |
| 24ec. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24ec. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24ed. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24ed. Date of Injury (Month, Day, Year) | | |
| 24ee. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24ee. Time of Injury M | | |
| 24ef. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24ef. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24eg. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24eg. Date of Injury (Month, Day, Year) | | |
| 24eh. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24eh. Time of Injury M | | |
| 24ei. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24ei. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24ej. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24ej. Date of Injury (Month, Day, Year) | | |
| 24ek. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24ek. Time of Injury M | | |
| 24el. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24el. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24em. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24em. Date of Injury (Month, Day, Year) | | |
| 24en. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24en. Time of Injury M | | |
| 24eo. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24eo. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24ep. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24ep. Date of Injury (Month, Day, Year) | | |
| 24eq. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24eq. Time of Injury M | | |
| 24er. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24er. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24es. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24es. Date of Injury (Month, Day, Year) | | |
| 24et. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24et. Time of Injury M | | |
| 24eu. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24eu. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24ev. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24ev. Date of Injury (Month, Day, Year) | | |
| 24ew. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24ew. Time of Injury M | | |
| 24ex. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24ex. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24ey. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24ey. Date of Injury (Month, Day, Year) | | |
| 24ez. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24ez. Time of Injury M | | |
| 24fa. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24fa. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24fb. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24fb. Date of Injury (Month, Day, Year) | | |
| 24fc. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24fc. Time of Injury M | | |
| 24fd. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24fd. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24fe. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24fe. Date of Injury (Month, Day, Year) | | |
| 24ff. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24ff. Time of Injury M | | |
| 24fg. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24fg. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24fh. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24fh. Date of Injury (Month, Day, Year) | | |
| 24fi. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24fi. Time of Injury M | | |
| 24fj. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24fj. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24fk. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24fk. Date of Injury (Month, Day, Year) | | |
| 24fl. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24fl. Time of Injury M | | |
| 24fm. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24fm. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24fn. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24fn. Date of Injury (Month, Day, Year) | | |
| 24fo. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24fo. Time of Injury M | | |
| 24fp. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24fp. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24fq. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24fq. Date of Injury (Month, Day, Year) | | |
| 24fr. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24fr. Time of Injury M | | |
| 24fs. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24fs. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24ft. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24ft. Date of Injury (Month, Day, Year) | | |
| 24fu. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24fu. Time of Injury M | | |
| 24fv. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24fv. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24fw. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24fw. Date of Injury (Month, Day, Year) | | |
| 24fx. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24fx. Time of Injury M | | |
| 24fy. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24fy. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24fz. Date of Injury (Month, Day, Year) | | 24de. Time of Injury M | | 24df. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24fz. Date of Injury (Month, Day, Year) | | |
| 24ga. Time of Injury M | | 24de. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24df. Date of Injury (Month, Day, Year) | | 24ga. Time of Injury M | | |
| 24gb. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24de. Date of Injury (Month, Day, Year) | | 24df. Time of Injury M | | 24gb. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |

Handwritten text, possibly a signature or date, located in the center of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36265

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|---|--|---|--|--------------------------------------|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Gertrude Born Nesterenko | | | | 2. Date of Death Month Day Year September 24, 1999 | | | | 3. Time of Death 2:45 p.m. | | |
| | 4a. Facility Name (If not institution, give street and number) 4016 Born Road | | | | 4b. City, Town, or Location of Death Jarrettsville | | | | 4c. County of Death Harford | | |
| Funeral Director | 5. Social Security Number 213-16-4025 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 93 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 5, 1905 | | 9. Birthplace (State or Foreign Country) Germany | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County Harford | | 10c. City, Town or Location Jarrettsville | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 4016 Born Road | | | | 10f. Zip Code 21084 | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) Konrad Born | | | | 18. Mother's Name (First, Middle, Maiden Surname) Amanda Kerst | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ilma Roskopf | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2422 Pellham Avenue, Baltimore, Maryland 21213 | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Washington Cr. 11/11/99 | | | | 20c. Location - City or Town, State Laurel, Maryland | | | |
| 21. Signature of Funeral Service Licensee <i>Janice B. [Signature]</i> | | | | 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, MD 20707 for Anatomical Gift Foundation | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cerebrovascular Accident</i> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death <i>Two weeks</i> | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alzheimer's Dementia</i> | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | | | | 28d. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature] MD</i> | | | | 29c. License number <i>D34652</i> | | | | 29d. Date signed (Month, Day, Year) <i>October 29, 1999</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Scott Haswell 2 North Avenue Bel Air Maryland 21014</i> | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | |

Handwritten signature or initials

NOV 1 9 1955

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36266

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Patricia M. Owensby

2. Date of Death
Month Day Year
November 17, 1999

3. Time of Death
1:14 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

217-38-5006

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

7-4-1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

113 Margaret Avenue

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

In own home

17. Father's Name (First, Middle, Last)

Henry C. Wise

18. Mother's Name (First, Middle, Maiden Surname)

Mary Garrett

19a. Informant's Name/Relationship (Type, Print) spouse

Mr. Jack Owensby Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

113 Margaret Avenue, Baltimore, Md. 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oaklawn

Date

11/19/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Joseph N. Zannino Jr.

22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Hm

263 S. Conkling St., Baltimore, Maryland 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Cle MD

29c. License number

RD191775

29d. Date signed (Month, Day, Year)

11/17/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Madai Chardon 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

[Signature]

State
Registrar

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

OWENSBY, PATRICIA
Baltimore, Maryland 21215-0020

NOV 1 8 1958

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36267

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|---|--|--|--|--|--|--|---|--------------------------------------|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Willie Runyon | | | | 2. Date of Death Month November Day 18 Year 1999 | | | | 3. Time of Death 10:00am | | | |
| | 4a. Facility Name (If not institution, give street and number) Meridian Brightwood Nursing Home | | | | 4b. City, Town, or Location of Death Lutherville | | | | 4c. County of Death Baltimore | | | |
| Funeral Director | 5. Social Security Number 235-22-8658 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) 6-17-1923 | | 9. Birthplace (State or Foreign Country) West Virginia | | | |
| | Usual Residence of Decedent | | | | 10a. State MD | | | | 10b. County Baltimore | | 10c. City, Town or Location Lutherville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 Yes 2 No | | | | 10e. Street and Number 12 Brookfield Garth | | | | 10f. Zip Code 21093 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) 12th | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive | | | | 16b. Kind of Business/Industry Public Service | | | |
| | 17. Father's Name (First, Middle, Last) Floyd Runyon | | | | 18. Mother's Name (First, Middle, Maiden Surname) Leodie Hensley | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) spouse Patricia (Little) Runyon | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Brookfield Garth, Lutherville, Maryland 21093 | | | | | | | |
| | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery | | | | 20c. Location - City or Town, State 11/22/99 Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Home 263 S. Conkling Street, Baltimore, Maryland 21224 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia Due to (or as a consequence of): Chronic Obstructive Lung Disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death 1-2 wks years | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia with Delusions Parkinson's Disease | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | | 24a. Was an autopsy performed? 1 Yes 2 No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | |
| | 25. Was case referred to medical examiner? 1 Yes 2 No | | | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | |
| 27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | | | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No | | | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Attending | | | | 29c. License number D17118 | | | | |
| 29d. Date signed (Month, Day, Year) Nov 18, 1999 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Schwartz M.D. 115 E. Melrose Ave 21212 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | | | 32. Registrar's Signature | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

108

[Faint, illegible handwritten text covering the majority of the page]

NOV 13 1911

ADH
EVELYN SINNERS
99-6865-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36268
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN M. SINNERS

2. Date of Death
Month Day Year
NOVEMBER 16, 1999

3. Time of Death
2142 PM

4a. Facility Name (If not institution, give street and number)

BAYVIEW HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number
217-14-0905

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)
86 Yrs.

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)
JUNE 23, 1913

9. Birthplace (State or Foreign
Country)
MARYLAND

Usual Residence of Decedent

10a. State
MARYLAND

10b. County
N/A

10c. City, Town or Location
BALTIMORE

10d. Inside City Limits
1 ☒ Yes 2 ☐ No

10e. Street and Number

25 N. CLINTON STREET

10f. Zip Code

21224

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.
Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)
12TH GRADE

College (14 or 5+)

18a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

REFRIGERATION COMPANY

17. Father's Name (First, Middle, Last)

JOHN S. SINNERS

18. Mother's Name (First, Middle, Maiden Surname)

MAGDALENA GAREY

19a. Informant's Name/Relationship (Type, Print)

MRS. NAOMI M. WOLF (Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3707 INA AVENUE, BALTIMORE, MARYLAND 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

OAK LAWN

Date

11/20/99 BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Mark T. [Signature]

22. Name and Address of Facility

SCHIMUNEK FUNERAL HOME INC.

3331 BREHMS LANE, BALTIMORE, MARYLAND 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Head and Neck Injuries
Due to (or as a consequence of):

b. Complicating Hypertensive
Due to (or as a consequence of):

c. and atherosclerotic Cardiovascular
Due to (or as a consequence of):
Disease

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy
performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☒ Accident 6 ☐ Could not be
3 ☐ Suicide 4 ☐ Homicide determined

28a. Date of Injury
(Month, Day, Year)
11/16/99

28b. Time of Injury
(Hour, Min)
2:15 PM

28c. Injury at Work?
1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject Fell

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

Home; 25 N. Clinton St; Baltimore, Md.

29a. Certifier
(Check only
one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joseph Pestana, MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

NOVEMBER 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pestana, 11 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

NOV 19 1999

Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

ORIGINAL

2007 2 1 VOR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36269

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Schultz

2. Date of Death
Month Day Year
November 18, 19993. Time of Death
3:00 a.m.

4a. Facility Name (If not Institution, give street and number)

Mariner Health of Kensington

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

217-76-0505

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

51

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 22, 1947

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3000 McComas Avenue

10f. Zip Code

20895

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

Disabled

17. Father's Name (First, Middle, Last)

William J. Schultz

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy E. Rice

19a. Informant's Name/Relationship (Type, Print)

Cathy Rosenberger/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9266 Cherry Lane, Laurel, Maryland 20708

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Washington Cr. 11/19

Date

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septicemia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Mental Retardation; Recurrent Aspiration;

Pneumonia; Multiple Visceral Anomalies

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicida 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Martin C. Shargel, M.D.

29c. License number

D08944

29d. Date signed (Month, Day, Year)

11/18/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin C. Shargel, M.D. 3720 Farragut Avenue, Kensington, Maryland 20895

31. Date filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

NOV 18 1953

Smith & Wadsworth

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36270

Certificate of Death

Reg. No.

AMENDED ITEM #5 PER FH G777 11/19/99 AH

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

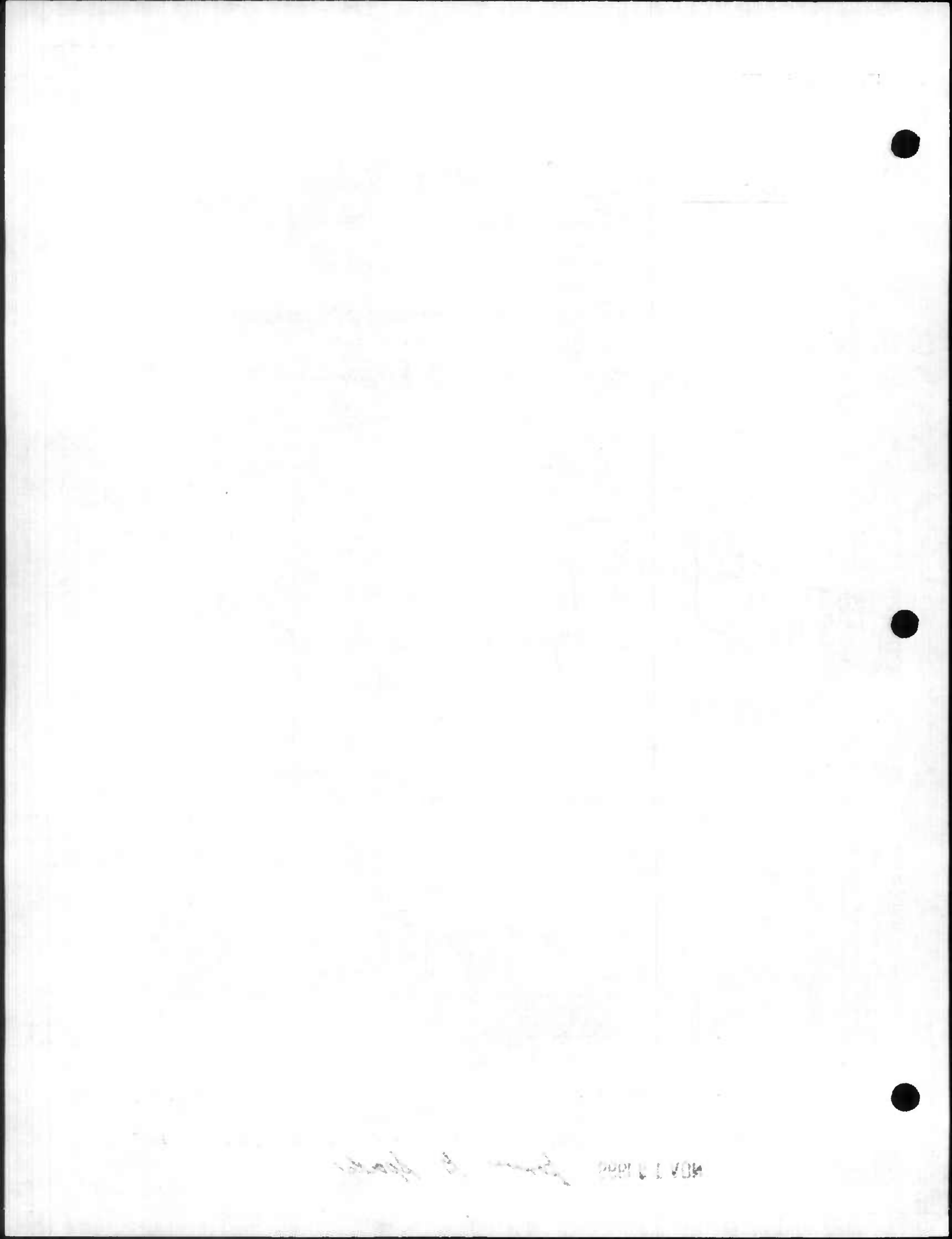
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
DirectorPhysician
/Medical
Examiner

| | | | | | |
|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Lucia Elsa Thornton | | 2. Date of Death Month Day Year November 18, 1999 | | 3. Time of Death 1:00pm | |
| 4a. Facility Name (If not institution, give street and number) 10 Valley Frost Court, apt. G | | 4b. City, Town, or Location of Death Cockeysville | | 4c. County of Death Baltimore | |
| 5. Social Security Number 550-07-4282 550-07-4782 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 95 Yrs. | |
| 8. Date of Birth (Month, Day, Year) March 17, 1904 | | 9. Birthplace (State or Foreign Country) Germany | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Cockeysville | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 10 Valley Frost Court, apt. G | | 10f. Zip Code 21030 | |
| 10g. Citizen of What Country? USA | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | 17. Father's Name (First, Middle, Last) Paul Alex Krum | |
| 18. Mother's Name (First, Middle, Maiden Surname) Martha Maria Schmidt | | 19a. Informant's Name/Relationship (Type, Print) Myrtle Badger/Friend | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 818 F. Cinnamon Ridge Place, Cockeysville, MD 21030 | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore-Washington Crematory | | 20c. Location - City or Town, State Laurel, Maryland | |
| 21. Signature of Funeral Service Licensee Bryan W. Clary | | 22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Robert Stoltz, MD | | 29c. License number D30910 | |
| 29d. Date signed (Month, Day, Year) December 19, 1999 | | 29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Stoltz, MD 1447 York Road, suite 605, Lutherville, MD 21093 | | 30. Date filed (Month, Day, Year) NOV 19 1999 | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature B Sparks | | 33. State Registrar State Registrar | |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36271

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|--------------------------|---|---|--|--|--|--|---|----------------------------|----------|----------------------------------|--|------------------------|----------|----------------------------------|--|--|-------------------|----------|----------------------------------|--|---------------------|----------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary G. Tichnell | | | | 2. Date of Death Month Day Year NOVEMBER 9 1999 | | 3. Time of Death 1:30 AM | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death CUMBERLAND | | 4c. County of Death ALLEGANY | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 214-05-7925 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 7, 1914 | | | | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) MD | | | | | | | | | | | | | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. State MD | | 10b. County Allegheny | | 10c. City, Town or Location Cumberland | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 10e. Street and Number 43 Race Street | | | | 10f. Zip Code 21502 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: XXX | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) housewife | | | 16b. Kind of Business/Industry own home | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Marcus W. Volk | | | | 18. Mother's Name (First, Middle, Maiden Surname) unknown | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary G. Dederer/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9220 West San Miguel, Glendale, AZ 85305 | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>e. INTRACRANIAL HEMORRHAGE</td> <td>24 HOURS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. RESPIRATORY FAILURE</td> <td>24 HOURS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="3">Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c. UPPER GI BLEED</td> <td>24 HOURS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>d. THROMBOCYTOPENIA</td> <td>24 HOURS</td> </tr> </table> | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | e. INTRACRANIAL HEMORRHAGE | 24 HOURS | Due to (or as a consequence of): | | b. RESPIRATORY FAILURE | 24 HOURS | Due to (or as a consequence of): | | Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. UPPER GI BLEED | 24 HOURS | Due to (or as a consequence of): | | d. THROMBOCYTOPENIA | 24 HOURS |
| Immediate Cause (Final disease or condition resulting in death) | e. INTRACRANIAL HEMORRHAGE | 24 HOURS | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | |
| | b. RESPIRATORY FAILURE | 24 HOURS | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | |
| Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. UPPER GI BLEED | 24 HOURS | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | |
| | d. THROMBOCYTOPENIA | 24 HOURS | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| | | | 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier Paula Waddy | | | | 29c. License number D 55079 | | | 29d. Date signed (Month, Day, Year) NOVEMBER 9, 1999 | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. PAULA WADDY, 47 VIRGINIA AVENUE, CUMBERLAND, MD 21502 | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | | 32. Registrar's Signature Benita B Sparks | | | | | | | | | | | | | | | | | | | | | |

ORIGINAL

NOV 1 1960

jhm
SARAH
TYLER BEY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


State of Maryland / Department of Health and Mental Hygiene 99 36272
AMEND ITEMS: #23 PART I, 27 PER 9/17/11-30-99 WR.
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

| | | | | | | | | | |
|--|--|--|---|---|--------------------------------|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) SARAH MI'AISHA TYLER-BEY | | | | 2. Date of Death Month Day Year NOVEMBER 15, 1999 | | | | 3. Time of Death 00:35 AM | |
| 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death N/A | |
| 5. Social Security Number 220-15-8788 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 12 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JUN 19 1987 | | 9. Birthplace (State or Foreign Country) MARYLAND | |

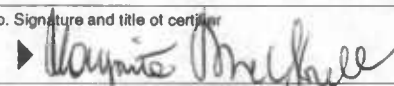

Funeral
Director

| | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE CITY | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 3822 BELLE AVENUE | | | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 7th grade | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STUDENT | | | 16b. Kind of Business/Industry MIDDLE SCHOOL | | |
| 17. Father's Name (First, Middle, Last) WILLIAM F TYLER-BEY | | | | 18. Mother's Name (First, Middle, Maiden Surname) BARBARA FINNEY-EL | | | | | |
| 19e. Informant's Name/Relationship (Type, Print) Barbara Finney-El/Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3822 Belle Avenue, Baltimore, Maryland 21215 | | | | | |
| 20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT ZION CEMETERY | | Date 11-19 | | 20c. Location - City or Town, State LANDSDOWNE, MARYLAND | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE | | | | | |

Physician
/Medical
Examiner

| | | | |
|--|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASTHMA a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |

To Be Completed by Physician/Medical Examiner

| | | | | | | | | | |
|--|--|---|--|-----------------------------|--|--|--|-----------------------------------|--|
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) NOVEMBER 15, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAYWARD A. KOROTCHUK 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature  | | | | | | | |

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36273

| | | | | | |
|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GRETA THOMPSON | | 2. Date of Death Month Nov Day 13 Year 99 | | 3. Time of Death 8:30 a.m. |
| | 4a. Facility Name (If not institution, give street and number) Howard County General Hospital | | 4b. City, Town, or Location of Death Columbia | | 4c. County of Death Howard |
| Funeral Director | 5. Social Security Number 578-16-2248 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) April 17, 1912 | | 9. Birthplace (State or Foreign Country) Washington, DC | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State Maryland | | 10b. County Prince George |
| | 10c. City, Town or Location Laurel | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 13913 Briarwood Drive #121 | | 10f. Zip Code 20708 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk |
| | 16b. Kind of Business/Industry US Government | | 17. Father's Name (First, Middle, Last) Henry Lorleberg | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Cunningham |
| | 19a. Informant's Name/Relationship (Type, Print) Vincent E. Thompson/Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13913 Briarwood Drive #121, Laurel, Maryland 20708 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | 20c. Location - City or Town, State 11/15/99 Suitland, Maryland |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Hypertension Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. 10 year c. d. | | Approximate Interval Between Onset and Death 1 week 10 year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration and Electrolyte Imbalance | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number 24721 | | 29d. Date signed (Month, Day, Year) 11/14/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5425 S. Ave 14333 Laurel Bowie Rd. Laurel MD 20708 | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Handwritten signature

NOV 1 1950

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36274

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Florence M. Trocki

2. Date of Death
Month Day Year

November 15, 1999

3. Time of Death

5:30 P.M.

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216.18.7593

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

08 26 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8813 Avondale Rd.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Elmer Bentz

18. Mother's Name (First, Middle, Maiden Surname)

Marie Neuberger

19a. Informant's Name/Relationship (Type, Print)

Alice Coleman/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8813 Avondale Rd. Baltimore, MD 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Balti/Washingt Crem.

Date

11/19/99

20c. Location - City or Town, State

Laurel, MD

21. Signature of Funeral Service Licensee

► Mark Marshall

22. Name and Address of Facility

Bradley-Ashton-Matthews Funeral Home Inc.
2134 Willow Spring Rd. Baltimore, MD 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Diabetes Mellitus

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Accident

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Marco Zamora, MD

29c. License number

D40819

29d. Date signed (Month, Day, Year)

November 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. MARCO ZAMORA 9000 FRANKLIN SQUARE DR. BALTIMORE, MARYLAND 21237

31. Date filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

James B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Florence Trocki

AA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36275

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mae E Vass

2. Date of Death

Month
11Day
12Year
99

3. Time of Death

3:20 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George

5. Social Security Number

579-42-6977

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

65

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Jan. 19, 1934

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Savage

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8329 Woodward Street

10f. Zip Code

20763

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Tony Piscitelli

18. Mother's Name (First, Middle, Maiden Surname)

Francis Lillian King

19a. Informant's Name/Relationship (Type, Print)

Thomas Vass/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Box 334, Haymarket, Virginia 20168

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Stonewall Memory Gardens 11/16

Date

20c. Location - City or Town, State

Manassas, Virginia

21. Signature of Funeral Service Licensee

Janice A. Paek

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, MD 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ADULT RESPIRATORY DISTRESS SYNDROME

Approximate Interval Between Onset and Death

3 WEEKS

Due to (or as a consequence of):

b. CARDIORESPIRATORY ARREST

Due to (or as a consequence of):

c. CARDIOMYOPATHY

Due to (or as a consequence of):

d. MYOCARDIAL INFARCTION

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA, SEPSIS DIABETES MELLITUS

RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

Janice A. Paek

29c. License number

D24035

29d. Date signed (Month, Day, Year)

11/13/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. M. HARRIS

321

PRINCE GEORGE ST

LAUREL

MD 20701

State
Registrar

31. Date filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

Benjamin S. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, R

1964

14

[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]

Handwritten signature or initials.

99-6860-510

cm

Harvey Watkins

AMENDED TIEM # 10e PER FH G777 11/19/99 AH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36276

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Harvey Gilbert Watkins, Sr.

2. Date of Death

November 16, 1999

3. Time of Death

2:37 P.M.

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

226-28-8412

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

09-30-25

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1621 N MONTFORD AVE

~~1621 N. Montford Avenue~~

10f. Zip Code

21205

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Isham

Watkins

18. Mother's Name (First, Middle, Maiden Surname)

Mary

Bagley

19a. Informant's Name/Relationship (Type, Print)

Margaret

Brown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

301 Shenandoah Avenue Baltimore, MD 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crownsville VA Cem. 11-19-99 Crownsville, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Baltimore, Maryland 21202

WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

Limited

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

November 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pestaner

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

State Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Handwritten signature

NOV 1 1963

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36277

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--|---|---|--|---|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Stella Rose Wisner | | | | 2. Date of Death Month Day Year November 15, 1999 | | 3. Time of Death 7:31 PM | | | |
| | 4a. Facility Name (If not institution, give street and number) Gilchrist Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | | | |
| Funeral Director | 5. Social Security Number 205-22-2311 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 69 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 31, 1930 | | 9. Birthplace (State or Foreign Country) Pennsylvania | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number 1 Thomas Point Court | | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? U.S.A. | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner | | 16b. Kind of Business/Industry Food Sales | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Peter Gorman | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mildred Long | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mr. Kenneth D. Wisner (husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Thomas Point Ct., Baltimore, MD 21234 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem. | | Date 11/19/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee B. A. Wilkins | | 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236 | | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ovarian Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death 2 years | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice | | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier Dr. Anthony Riley, MD | | | 29c. License number D25205 | | | 29d. Date signed (Month, Day, Year) November 16, 1999 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W-A. Riley & BMD 6701 N. Charles St. Balto. md 21205 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature [Signature] | | | | | | | |

99-6863-510

STANLEY
WILSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36278
Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)
STANLEY A. WILSON

2. Date of Death
Month: NOVEMBER, Day: 16, Year: 1999

3. Time of Death
7:04P.M.

4a. Facility Name (If not institution, give street and number)
3000 BLK W.GARRISON AVE

4b. City, Town, or Location of Death
BALTIMORE

4c. County of Death
NA

5. Social Security Number
216-92-7493

6. Sex
☒ M ☐ F

7. Age (In yrs. last birthday)
20 Yrs.

8. Date of Birth (Month, Day, Year)
Dec. 13 1978

9. Birthplace (State or Foreign Country)
MD

10a. State
MD

10b. County
NA

10c. City, Town or Location
BALTIMORE

10d. Inside City Limits
☒ Yes ☐ No

10e. Street and Number
3861 SHANNON DRIVE

10f. Zip Code
21213

10g. Citizen of What Country?
USA

11. Marital Status
☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?
☐ Yes ☒ No

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.
Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MOVER (FURNITURE)

16b. Kind of Business/Industry
LAUREL VAN LINES

17. Father's Name (First, Middle, Last)
STANLEY A. WILSON

18. Mother's Name (First, Middle, Maiden Surname)
LESLIE HUBBARD

19a. Informant's Name/Relationship (Type, Print)
LESLIE HUBBARD - MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3861 SHANNON DRIVE BALTIMORE, MD 21213

20a. Method of Disposition
☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)
KING MEMORIAL PARK

20c. Location - City or Town, State
112099 RANDALLSTOWN, MARYLAND

21. Signature of Funeral Service Licensee
Phyllis B. Harris

22. Name and Address of Facility
MARCH FUNERAL HOME WEST, INC.
4300 WABASH AVE. BALTIMORE, MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Multiple gunshot wounds
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23c. Did tobacco use contribute to the cause of death?
☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?
☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?
☒ Yes ☐ No

25. Was case referred to medical examiner?
☒ Yes ☐ No

26. Place of Death (Check only one)
Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA
Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify) SCENE

27. Manner of Death
☐ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☒ Homicide

28a. Date of Injury (Month, Day Year)
11-16-99

28b. Time of Injury
18:52 P M

28c. Injury at Work?
☐ Yes ☒ No

28d. Describe how injury occurred
SHOOTER WAS SHOT.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
CAR

28f. Location (Street and Number or Rural Route Number, City or Town, State)
3000 BLK W. GARRISON AVE BALTIMORE

29a. Certifier (Check only one)
☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

29b. Signature and title of certifier
Wayne D. Kozak

29c. License number
O.C.M.E.

29d. Date signed (Month, Day, Year)
NOVEMBER 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wayne D. Kozak M.D.
111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)
NOV 19 1999

32. Registrar's Signature
[Signature]

State Registrar

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM 11#778 12-2-99 WR. State of Maryland / Department of Health and Mental Hygiene **99 36279**
Certificate of Death Reg. No.

Physician
/Medical
Examiner

| | | | | | | | |
|--|--|--|--|--|--------------------------------|---|--|
| 1. Decedent's Name (First, Middle, Last) Charles William Yowell Sr | | | | 2. Date of Death Month 11 Day 13 Year 99 | | 3. Time of Death 1735 | |
| 4a. Facility Name (If not institution, give street and number) Deaton Medical Center | | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death N/A | |
| 5. Social Security Number 217-14-1376 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 77 Yrs. | It Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 1, 1922 | |
| 9. Birthplace (State or Foreign Country) Baltimore Maryland | | | | | | | |

Funeral
Director

| | | | | | | | |
|-----------------------------|--|-------------------------------|--|---------------------------|--|--|--|
| Usual Residence of Decedent | | 10a. State Maryland | | 10b. County N/A | 10c. City, Town or Location Baltimore City | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|-----------------------------|--|-------------------------------|--|---------------------------|--|--|--|

| | | | | |
|---|--|-------------------------------|---|--|
| 10e. Street and Number 601 North Charles Street | | 10f. Zip Code 21230 | 10g. Citizen of What Country? United States | |
|---|--|-------------------------------|---|--|

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Marines WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
|---|--|---|--|--|--|---|--|

| | | | | | |
|--|--|---|--|---|--|
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) 0 | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security Guard | | 16b. Kind of Business/Industry Security | |
|--|--|---|--|---|--|

| | | | |
|---|--|---|--|
| 17. Father's Name (First, Middle, Last) Charles H. Yowell | | 18. Mother's Name (First, Middle, Maiden Surname) Lena V. Smith | |
|---|--|---|--|

| | | | |
|---|--|--|--|
| 19a. Informant's Name/Relationship (Type, Print) Geraldine V. Yowell / Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 Light Street, Baltimore Maryland 21230, Apt# 626 | |
|---|--|--|--|

| | | | | | |
|--|--|---|--|-------------------------------------|--|
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park, November 16, 1999 Baltimore Maryland | | 20c. Location - City or Town, State | |
|--|--|---|--|-------------------------------------|--|

| | | | |
|---|--|--|--|
| 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. | | 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 | |
|---|--|--|--|

| | | | |
|---|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diabetes Mellitus Stroke Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | Approximate interval Between Onset and Death 2 days | |
|---|--|---|--|

| | | | |
|---|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Stroke | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |

| | | | |
|---|--|---|--|
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day, Year) 11/14/99 | |
| | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |

| | |
|---|--|
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
|---|--|

| | | | | | |
|--|--|--------------------------------------|--|--|--|
| 29b. Signature and title of certifier [Signature] MD | | 29c. License number D38675 | | 29d. Date signed (Month, Day, Year) 11/14/99 | |
|--|--|--------------------------------------|--|--|--|

| | |
|---|--|
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JDELL MESHULAM 1147 SHANOVER ST BALTIMORE MD 21230 | |
|---|--|

| | | | |
|---|--|---|--|
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature [Signature] | |
|---|--|---|--|

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

NOV 1 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36280

Certificate of Death

Reg. No.

Physician
(Medical
Examiner)

1. Decedent's Name (First, Middle, Last)

Jaffar Hassan Syed Zaidi

2. Date of Death

November 11, 1999

Day

Year

3. Time of Death

5:29 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Doctors Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George

5. Social Security Number

214-06-4448

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

59

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sept. 26, 1940

9. Birthplace (State or Foreign Country)

India

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4606 Holmehurst Way

10f. Zip Code

20720

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Asian Indian

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (14 or 5+)
416a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Sales Representative

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Syed Farzand Hassan Zaidi

18. Mother's Name (First, Middle, Maiden Surname)

Fathma Thair

19a. Informant's Name/Relationship (Type, Print)

Syed Masood Zaidi/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8373 Irongate Way, Manassas, Virginia 20109

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MD National Mem. Park

Date

11/12/99

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. ACUTE MYOCARDIAL INFARCTION 2 DAYS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ARTERIO SCLEROTIC HEART DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Arvind M. Mehta MD

D27366

11/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARVIND M. MEHTA 7601 Baltimore Ave #509 College Park MD 20742

State
Registrar

31. Date filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

Benjamin S. Sparks

ORIGINAL

Jaffar Hassan Syed Zaidi
Baltimore, Maryland 21215-0020Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21268-0760permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
(Medical
Examiner)

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Handwritten signature

NOV 1 3 1955

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
REG ME 6778 12-8-99 WR. 99 36281
Certificate of Death

AMEND ITEMS: #23 PART I, II 27 28A-F

Reg. No.

| | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GEORGE CLARENCE ALBRIGHT, SR. | | | | | | 2. Date of Death Month November Day 12 Year 1999 | | 3. Time of Death 05:54 AM. | |
| | 4a. Facility Name (If not institution, give street and number) Carroll County General Hospital | | | | | | 4b. City, Town, or Location of Death Westminster | | 4c. County of Death CARROLL | |
| Funeral Director | 5. Social Security Number 215-34-5159 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 60 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov 27, 1938 | | 9. Birthplace (State or Foreign Country) Pennsylvania | |
| | Usual Residence of Decedent | | | | | | 10a. State Maryland | | 10b. County Carroll | |
| To Be Completed by Funeral Director | 10c. City, Town or Location Westminster | | | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number 53 East Main Street | | | | | | 10f. Zip Code 21157 | | 10g. Citizen of What Country? United States | |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver | | 16b. Kind of Business/Industry Construction | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Clarence Eli Albright | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Beatrice Romaine Werner | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Donna Wagner/daughter | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3931 Sunset Drive, Hampstead, MD 21074 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation | | 20c. Date 11/15/99 | | 20d. Location - City or Town, State Hampstead, MD | | | |
| | 21. Signature of Funeral Service Licensee <i>Steven S. Radentz</i> | | | | | | 22. Name and Address of Facility Myers Funeral Home 91 Willis Street Westminster, MD 21157 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PULMONARY THROMBOEMBOLISM COMPLICATED BY FRACTURE OF NECK | | | | | | Approximate Interval Between Onset and Death | | | |
| | Immediate Cause (Final disease or condition resulting in death) OF NECK | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. STATUS POST SKIN CANCER SURGERY, LEFT LEG | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 11-12-99 | | 28b. Time of Injury 4:50 M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred SUBJECT FELL IN BATHROOM | |
| To Be Completed by Physician/Medical Examiner | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) RESIDENCE | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 53 E. MAIN ST. CARROLL COUNTY, MD | | | | | | | |
| | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | 29b. Signature and title of certifier <i>Stephen S. Radentz</i> | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number O.C.M.E. | | | | | | 29d. Date signed (Month, Day, Year) November 12, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 15 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | | |

Handwritten signature

NOV 12 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36282

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|---|--|--|--|--|--|---|----|---------------|--|----------------------------------|--|----|---|----------------------------------|--|----|--|------------------------|--|----------------------------------|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Rosa Marie Breazil | | | | 2. Date of Death Month Day Year November 7 1999 | | 3. Time of Death 12:18 | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Deten Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death None | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 054-60-2262 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 35 | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 28, 64 | 9. Birthplace (State or Foreign Country) New York | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location Hughesville | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | |
| 10e. State Maryland | | 10b. County Charles | | 10f. Zip Code 20637 | | 10g. Citizen of What Country? U.S.A. | | | | | | | | | | | | | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Domestic | | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Roosevelt Cauthen | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Cauthen | | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary Cauthen/ Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12831 Grosstown Road, Hughesville MD 20637 | | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Marys Ch | | 20c. Location - City or Town, State 11/12/99 Bryantown Maryland | | | | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility M00191 ADAMS FUNERAL HOME P.A. AQUASCO MD 20608 | | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>e.</td> <td>sepsis</td> <td rowspan="4"> Approximate Interval Between Onset and Death 1 week months years </td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>f.</td> <td>mycobacterium avium intracellulare</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="2">g.</td> <td>AIDS - advanced</td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | e. | sepsis | Approximate Interval Between Onset and Death 1 week months years | Due to (or as a consequence of): | | f. | mycobacterium avium intracellulare | Due to (or as a consequence of): | | g. | | AIDS - advanced | | Due to (or as a consequence of): | | | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | e. | sepsis | Approximate Interval Between Onset and Death 1 week months years | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | |
| | f. | mycobacterium avium intracellulare | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | |
| g. | | AIDS - advanced | | | | | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. tuberculosis, anaemia of chronic disease, HSV-II | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) N/A | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D52394 | | 29d. Date signed (Month, Day, Year) 11-8-1999 | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ila Mulasi, 611 S. Charles St., Baltimore MD 21230 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 10 1999 | | 32. Registrar's Signature | | | | | | | | | | | | | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36283

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CECILIA BENNETT | | | | 2. Date of Death Month Day Year NOVEMBER 9, 1999 | | | | 3. Time of Death 4:54AM | |
| | 4a. Facility Name (If not institution, give street and number) 300 HARFORD STREET-APARTMENT 3D | | | | 4b. City, Town, or Location of Death LA PLATA | | | | 4c. County of Death CHARLES | |
| Funeral Director | 5. Social Security Number 578-42-9375 | | 6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 94 Yrs. | | 8. Date of Birth (Month, Day, Year) SEPT. 19, 1905 | | 9. Birthplace (State or Foreign Country) NEW YORK | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | 10b. County CHARLES | | 10c. City, Town or Location LA PLATA | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 300 HARFORD STREET APT.#3-D | | | | 10f. Zip Code 20646 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 yrs. | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RESTAURANT OWNER | | | | 16b. Kind of Business/Industry SELF EMPLOYED FOODS | | | |
| | 17. Father's Name (First, Middle, Last) LEOPOLD LUPOVITCH | | | | 18. Mother's Name (First, Middle, Maiden Surname) SADIE GOTCH | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) SYLVIA POOLE DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS #10 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY MEM. GARDENS | | Date 11-12-99 | | 20c. Location - City or Town, State WALDORF, MARYLAND | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. LUNG CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death 6 months | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier  | | | | 29c. License number D15765 | |
| | 29d. Date signed (Month, Day, Year) 11-10-99 | | | | | | | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) A.H. FADUL, M.D. 6620 CRAIN HWY. SUITE 101 LA PLATA, MD. 20646 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) NOV 10 1999 | | | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36284

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Julia Baisley

2. Date of Death

November 1 1999

3. Time of Death

1:00pm

4a. Facility Name (If not institution, give street and number)

3702 Lochearn Drive

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

220-24-2120

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 19 1914

9. Birthplace (State or Foreign Country)

Pa.

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3702 Lochearn Dr

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
11

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

store manager

16b. Kind of Business/Industry

retail sales

17. Father's Name (First, Middle, Last)

John Krolick

18. Mother's Name (First, Middle, Maiden Surname)

Eva Boris

19a. Informant's Name/Relationship (Type, Print)

Patricia Garrison (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3702 Lochearn Dr. Baltimore, Md 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Memorial

Date

11-6-99

20c. Location - City or Town, State

Sykesville, Md

21. Signature of Funeral Service Licensee

▶ Page Haight Herbert

22. Name and Address of Facility

Haight Funeral Home & Chapel
P.O. Box 195 Sykesville, Md 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Essential Hypertension

Multiple Strokes

Aphasia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ Robert B. Kroppnick

29c. License number

014753

29d. Date signed (Month, Day, Year)

11/10/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert B. Kroppnick, M.D. 4000 Old Ct. Rd. Ste. 300 Pikesville, MD 21208

31. Date filed (Month, Day, Year)

NOV 04 1999

32. Registrar's Signature

▶ B. B. Kroppnick

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36285

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | |
|---|--|---|--------------------------------|--|
| 1. Decedent's Name (First, Middle, Last) RUTH MARIE BOWSER | | 2. Date of Death Month Nov. Day 1 Year 1999 | | 3. Time of Death 8:45 AM |
| 4a. Facility Name (If not institution, give street and number) 572 ASHER GLADE ROAD | | 4b. City, Town, or Location of Death FRIENDSVILLE MD | | 4c. County of Death GARRETT CO. |
| 5. Social Security Number 172-16-7570 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 80 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| 8. Date of Birth (Month, Day, Year) 9-11-19 | | 9. Birthplace (State or Foreign Country) COOLSPRING PA. | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10a. State MD | 10b. County GARRETT CO. | 10c. City, Town or Location FRIENDSVILLE MD | | |
| 10e. Street and Number 572 ASHER GLADE ROAD | | 10f. Zip Code 21531 | | 10g. Citizen of What Country? USA |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE | | 16b. Kind of Business/Industry OWN HOME |
| 17. Father's Name (First, Middle, Last) EDGAR DeVault | | 18. Mother's Name (First, Middle, Maiden Surname) LYDA SHOAF | | |
| 19a. Informant's Name/Relationship (Type, Print) RALPH BOWSER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 572 ASHER GLADE ROAD FRIENDSVILLE, MD 21531 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ASHER GLADE CEMETERY | | 20c. Location - City or Town, State 11-4-99 FRIENDSVILLE MD |
| 21. Signature of Funeral Service Licensee <i>Eric W. Sweet</i> M-00900 | | 22. Name and Address of Facility SOWERS FUNERAL HOME 60 W MAIN ST FROSTBURG, MD 21532 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive heart failure Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 10 years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Poorly controlled diabetes type II, Megacolon, chronic GI bleed, anemia, chronic renal failure | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| 29b. Signature and title of certifier <i>Margaret A. Kaiser M.D.</i> | | 29c. License number D26650 | | 29d. Date signed (Month, Day, Year) 11/1/99 |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Margaret A. Kaiser, M.D. PO Box 486 Oakland, MD 21550 | | | | |
| 31. Date filed (Month, Day, Year) NOV 08 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36286

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | |
|--|---|-------------------------|---|---|--|---|---|--|--|---|----|-------------------------|--|----|------|----|-------------|----|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) PINEY WILEY BEADLES | | | | | | 2. Date of Death Month Day Year NOVEMBER 5 1999 | | 3. Time of Death 16:28 PM | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL | | | | | | 4b. City, Town, or Location of Death CUMBERLAND | | 4c. County of Death ALLEGANY | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 231-20-1090 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) OCT 11 1918 | | 9. Birthplace (State or Foreign Country) KENTUCKY | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | |
| 10a. State MARYLAND | | 10b. County ALLEGANY | | 10c. City, Town or Location CUMBERLAND | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| 10e. Street and Number 1102 FREDERICK STREET | | | | | | 10f. Zip Code 21502 | | 10g. Citizen of What Country? U.S.A. | | | | | | | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOME MAKER | | | | 16b. Kind of Business/Industry HOME MAKER | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) MERIDE WILEY | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) CARRY STAPLETON | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) EDWARD D. SMALL SON | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RT#1 BOX# 178A KEYSER, W.VA. 26726 | | | | | | | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) SUNSET CEMETERY | | Date NOVEMBER 9 1999 | | 20c. Location - City or Town, State CUMBERLAND MARYLAND | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee Dale L. Merritt | | | | | | 22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Coronary artery disease</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>COPD</td> </tr> <tr> <td>c.</td> <td>lung Cancer</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. | Coronary artery disease | Approximate Interval Between Onset and Death | b. | COPD | c. | lung Cancer | d. | |
| Immediate Cause (Final disease or condition resulting in death) | a. | Coronary artery disease | Approximate Interval Between Onset and Death | | | | | | | | | | | | | | | | |
| | b. | COPD | | | | | | | | | | | | | | | | | |
| | c. | lung Cancer | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Carotid artery stenosis, hyperlipidemia | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| 28d. Describe how injury occurred | | | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier Dale L. Merritt M.D. | | | | | | 29c. License number D 46346 | | 29d. Date signed (Month, Day, Year) NOVEMBER 9, 1999 | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. HUMA SHAKIL 625 KENT AVE. CUMBERLAND MARYLAND 21502 | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 10 1999 | | | | | | 32. Registrar's Signature Huma Shakil | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Handwritten signature or initials.

2201 6 E VON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36287

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Boyden

2. Date of Death
Month Day Year

Nov. 03 1999

3. Time of Death

1:14 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

384-32-5836

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 10, 1936

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Hurlock

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6791 Whitely Road

10f. Zip Code

21643

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 53-72

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

United States Air Force

16b. Kind of Business/Industry

Officer

17. Father's Name (First, Middle, Last)

Harry Boyden

18. Mother's Name (First, Middle, Maiden Surname)

Alice Lucille Jelf Boyden

19a. Informant's Name/Relationship (Type, Print)

Donna F. Boyden/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6791 Whitely Road, Hurlock, MD 21643

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bloomery Cemetery

Date

11/7

20c. Location - City or Town, State

Federalsburg, MD

21. Signature of Funeral Service Licensee

Michael F. Eskow

22. Name and Address of Facility

Frampton-Hawkins-Eskow Funeral Home
Federalsburg, MD 21632

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary artery disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

P. Rannan Resident Physician

29c. License number

P12400

29d. Date signed (Month, Day, Year)

11/03/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 South Greene Street Baltimore, Maryland

31. Date filed (Month, Day, Year)

NOV - 5 1999

32. Registrar's Signature

S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36288

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) KATHLEEN MARIE BULLOCK | | | | 2. Date of Death Month NOV Day 9 Year 1999 | | 3. Time of Death 1630 | |
| | 4a. Facility Name (If not institution, give street and number) 2768 Choptank Main Street | | | | 4b. City, Town, or Location of Death Preston | | 4c. County of Death Caroline | |
| Funeral Director | 5. Social Security Number 220-03-6050 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) Mar. 18, 1919 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Caroline | | 10c. City, Town or Location Preston | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 2768 Choptank Main Street | | 10f. Zip Code 21655 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Seamstress | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress | | 16b. Kind of Business/Industry Sportswear | | | |
| | 17. Father's Name (First, Middle, Last) Roland Chambers | | | | 18. Mother's Name (First, Middle, Maiden Surname) Stella Chambers Chambers | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Barbara Quathamer/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 S. Hanson St., Easton, MD 21601 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Junior Order Cem. | | 20c. Location - City or Town, State 11/12 Preston, Maryland | | | |
| | 21. Signature of Funeral Service Licensee Michael F. Eskew | | 22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CAD Due to (or as a consequence of): NIDDM Due to (or as a consequence of): HTN Due to (or as a consequence of): CHF | | | | | | | |
| | Approximate Interval Between Onset and Death Immediate years years Months | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pancytopenia | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Kathryn Helesbeck, MD | | | | 29c. License number D0053114 | | 29d. Date signed (Month, Day, Year) 11/11/99 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 607 Dutchmans Lane Easton MD 21601 | | | | | | | | |
| 31. Date filed (Month, Day, Year) 11 NOV 12 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36289

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Albert Bruce BIESEL

2. Date of Death

November 5 1999 2 50 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Stella Maris at Mercy Hospice

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

-

Funeral
Director

5. Social Security Number

214 30 0831

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jan. 28, 1935

9. Birthplace (State or Foreign Country)

IL

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1573 Fallowfield Court

10f. Zip Code

21114

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1952-5313. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

electrical engineer

16b. Kind of Business/Industry

retail food distribu-
tion

17. Father's Name (First, Middle, Last)

William Trimble Biesel

18. Mother's Name (First, Middle, Maiden Surname)

Aileen Louise Jaquith

19a. Informant's Name/Relationship (Type, Print)

Rose Anne Biesel (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as 10 above

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

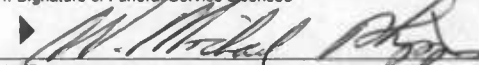
Date

11-6-99

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Rausch Funeral Home, Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Metastatic Lung Cancer
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. _____
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advanced chronic obstructive pulmonary disease
Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

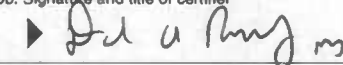
M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier



29c. License number

D40854

29d. Date signed (Month, Day, Year)

NOVEMBER 5, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID ROSENBERG 301 ST PAUL PI, BALTIMORE MD 21202

31. Date filed (Month, Day, Year)

NOV 08 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

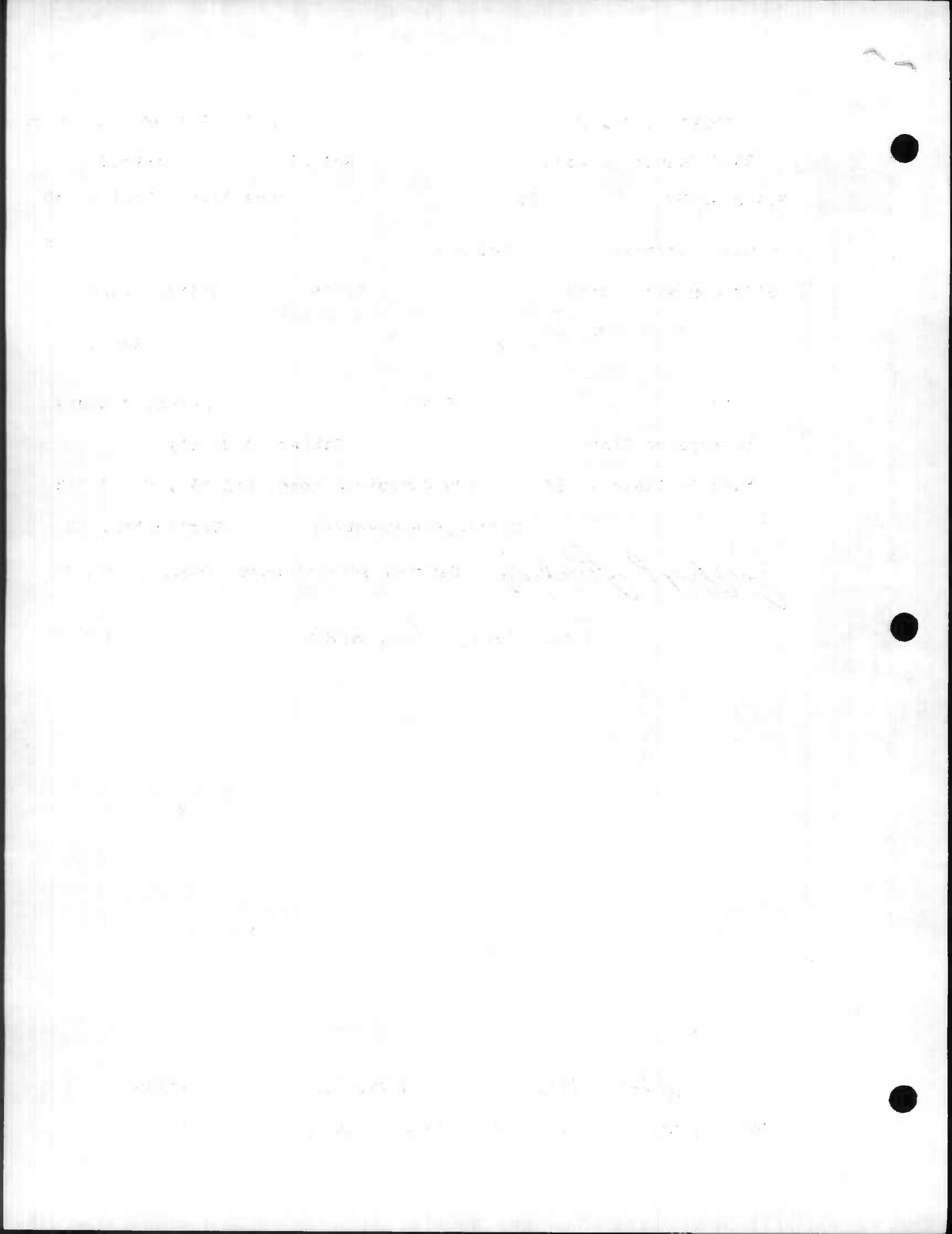
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State of Maryland / Department of Health and Mental Hygiene **99 36290**
Certificate of Death Reg. No.

Reg. No.

DMMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36291**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Vivian Collins

2. Date of Death
Month Day Year
November 3 19993. Time of Death
4:50 AM

4a. Facility Name (If not institution, give street and number)

Mariner Health of Forest Hill

4b. City, Town, or Location of Death

Forest Hill

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

219-18-5257

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 17, 1924

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Street

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3038 Conowingo Road

10f. Zip Code

21154

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Assembly Line Worker

16b. Kind of Business/Industry

Rubber Manufacturer

17. Father's Name (First, Middle, Last)

David Woodley Thompson

18. Mother's Name (First, Middle, Maiden Surname)

Olive Marie Rouse

19a. Informant's Name/Relationship (Type, Print)

Patricia White/ Daughter-in-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3038 Conowingo Rd., Street, MD 21154

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gardens

Date

11-6-99

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

Charles A. Emery

22. Name and Address of Facility

McComas Funeral Home, P.A.

50 W. Broadway Street, Bel Air, MD 21014

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

< 1m

b.

Due to (or as a consequence of):

< 1m

c.

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

large decubitus ulcer

peg tube

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David S. Dunn

29c. License number

D32299

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David S. Dunn 615 W. MacPh. 1

State
Registrar

31. Date filed (Month, Day, Year)

NOV 05 1999

Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36292

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|---|---|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DANIEL ROBERT CAMPBELL | | | | 2. Date of Death Month 11 Day 6 Year 99 | | 3. Time of Death 0330 | | |
| | 4a. Facility Name (If not institution, give street and number) OCEAN DOWNS | | | | 4b. City, Town, or Location of Death BERLIN | | 4c. County of Death WORCESTER | | |
| Funeral Director | 5. Social Security Number 108-38-8330 | | 6. Sex 1 M 2 F | 7. Age (In yrs. last birthday) 52 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 2-17-47 | 9. Birthplace (State or Foreign Country) NY | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD. | 10b. County WORCESTER | | 10c. City, Town or Location BERLIN | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number RACETRACK RD. | | | 10f. Zip Code 21811 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) EQUIP. OPERATOR | | 16b. Kind of Business/Industry CONSTRUCTION | | | | |
| | 17. Father's Name (First, Middle, Last) JOHN BOYD CAMPBELL | | | | 18. Mother's Name (First, Middle, Maiden Surname) RUTH PATHE | | | | |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print) LORRAINE F. CAMPBELL | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RACETRACK RD. BERLIN, MD. 21811 | | | | |
| | 20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) SALISBURY CREMATORY | | Date 11-9 | | 20c. Location - City or Town, State SALISBURY, MD. | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD. 21811 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End stage liver disease Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | 29c. License number-- DD053612 (Maryland) | | 29d. Date signed (Month, Day, Year) 11/8/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREA HOFFMAN MD MAIN ST. BERLIN, MD. 21811 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 09 1999 | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended # 17, Md.
11/4/99, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36293
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MILTON LEE CROWE

2. Date of Death

NOV 2 Day 1999

3. Time of Death

11:30 AM

4a. Facility Name (If not institution, give street and number)

11504 BOARDWALK AVE. NE

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral
Director

5. Social Security Number

217-28-0520

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUNE 19, 1931

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

11504 BOARDWALK AVE NE

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No 1952-
If Yes, Give
Year or Dates: 1953

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

WAREHOUSE MANAGER

16b. Kind of Business/Industry

RETAIL

17. Father's Name (First, Middle, Last)

SAMUEL W. CROWE

18. Mother's Name (First, Middle, Maiden Surname)

MELVA LEONA BROADWATER

19a. Informant's Name/Relationship (Type, Print)

SANDRA CROWE/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11504 BOARDWALK AVE NE, CUMBERLAND, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

NEW GERMANY
METHODIST CEMETERY

Date

NOV
5, 1999

20c. Location - City or Town, State

GRANTSVILLE, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

HAVER CHAPEL OF THE HILLS MORTUARY
1302 NATIONAL HWY, LAVALE, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. OAT CELL CARCINOMA, LUNG

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

ONE MONTH

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic Disease to the Bone,

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical
examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☒ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier
(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D-14865

29d. Date signed (Month, Day, Year)

NOV 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. J. BARRETT MD MEMORIAL HOSP. CUMBERLAND, MD 21502

State
Registrar

31. Date filed (Month, Day, Year)

NOV 04 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36294

| | | | | | | | | |
|---|--|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DALE LONDON CRABTREE | | | | 2. Date of Death Month Day Year November 8, 1999 | | 3. Time of Death 2115 | |
| | 4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL | | | | 4b. City, Town, or Location of Death CUMBERLAND | | 4c. County of Death ALLEGANY | |
| Funeral Director | 5. Social Security Number 214-32-2999 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 63 Yrs. | | 8. Date of Birth (Month, Day, Year) JUNE 3 1936 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MARYLAND | | 10b. County ALLEGANY | | 10c. City, Town or Location CORRIGANVILLE | |
| To Be Completed by Funeral Director | Usual Residence of Decedent 10a. State MARYLAND | | | | 10b. County ALLEGANY | | 10c. City, Town or Location CORRIGANVILLE | |
| | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 11115 CHARLOTTE AVE. | | | |
| To Be Completed by Physician/Medical Examiner | 10f. Zip Code 21524 | | | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: KOREAN | | | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BUSINESS AGENT LOCAL #1024 | | | |
| To Be Completed by Physician/Medical Examiner | 16b. Kind of Business/Industry CARPENTERS LOCAL 1024 | | | | 17. Father's Name (First, Middle, Last) JOSEPH CRABTREE | | | |
| | 18. Mother's Name (First, Middle, Maiden Surname) HELEN WILKENS | | | | 19. Informant's Name/Relationship (Type, Print) DORIS CRABTREE WIFE | | | |
| To Be Completed by Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX #245 ELLERSLIE, MARYLAND 21529 | | | | 20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | |
| | 20b. Place of Disposition (Name of cemetery, crematory or other place) ROCKY GAP VET CEMETERY NOV 12 1999 | | | | 20c. Location - City or Town, State FLINTSTONE MD.RFD | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Dale L. Merritt | | | | 22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. OAT CELL CARCINOMA, LUNG Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 7 MONTHS | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Robert J. Barrera, Jr. | | | |
| | 29c. License number D-14865 | | | | 29d. Date signed (Month, Day, Year) November 9, 1999 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR R. BARRERA MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND MARYLAND 21502 | | | | 31. Date filed (Month, Day, Year) NOV 10 1999 | | | |
| | 32. Registrar's Signature Barrera | | | | 33. Registrar's Signature Sparks | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten signature

NOV 11 1901

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36295

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Ruth D. Clark

2. Date of Death
Month Day Year

NOVEMBER 2 1999

3. Time of Death

7:55 PM

4a. Facility Name (If not institution, give street and number)

Mercy Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

213-24-4245

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Jan. 13, 1927

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

324 Melvin Avenue

10f. Zip Code

21228

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

House Keeper

16b. Kind of Business/Industry

Hotel Service

17. Father's Name (First, Middle, Last)

Roland Stephens

18. Mother's Name (First, Middle, Maiden Surname)

Pinkie Stephens

19a. Informant's Name/Relationship (Type, Print)

Randolph Clark/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

324 Melvin Ave. Baltimore, MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Thompsons town Cem.

Date

11-6

20c. Location - City or Town, State

Thompsons town, MD

21. Signature of Funeral Service Licensee

Roman G. Coale

22. Name and Address of Facility

Frampton-Hawkins-Eskow Funeral Home
216 N. Main St. Federalburg, MD 21632

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hepatocarcinoma
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one) STELLA MARIS AT MERCY

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David Riseberg

29c. License number

D 40854

29d. Date signed (Month, Day, Year)

NOVEMBER 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID RISEBERG 301 St Paul Pl BALTIMORE, MD 21202

31. Date filed (Month, Day, Year)

NOV - 9 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 36296

Reg. No.

| | | | | | | | | | | | | | | | |
|---|---|---|---|--------------------------|--|--|--|-----------------------------------|--|--|--|---------------------------------|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Kevin Michael Clark | | | | 2. Date of Death Month Day Year NOVEMBER 10, 1999 | | | | 3. Time of Death 524 | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) SACRED HERAT HOSPITAL | | | | 4b. City, Town, or Location of Death CUMBERLAND | | | | 4c. County of Death ALLEGANY | | | | | | |
| Funeral Director | 5. Social Security Number 218-98-6996 | | 6. Sex 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 34 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | | | | | |
| | 8. Date of Birth (Month, Day, Year) 15-Jul-65 | | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Garrett | | 10c. City, Town or Location Frostburg | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 1076 Finzel Road | | 10f. Zip Code 21532- | | 10g. Citizen of What Country? U.S.A. | | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) assistant cook | | 16b. Kind of Business/Industry senior citizen's center | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Paul G. Clark | | | | 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Wilhelm | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Paul G. Clark Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1042 Finzel Road Frostburg Maryland 21532- | | | | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Finzel Cemetery | | 20c. Date 15-Nov-99 | | 20d. Location - City or Town, State Finzel, Maryland | | | | | | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 | | | | | | | | | | |
| | 23a. Pertinent: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | 29b. Signature and title of certifier  | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) NOVEMBER 12, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. HEFLINGER 11 PENN STREET BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature  | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

MEMORANDUM FOR THE RECORD
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum format with a subject line and several lines of body text.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36297

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Clara Belle Bowen Cox | | | | 2. Date of Death Month Day Year Nov 8 1999 | | 3. Time of Death 7 pm | |
| | 4a. Facility Name (If not institution, give street and number) 5464 Sixes Road | | | | 4b. City, Town, or Location of Death Prince Frederick | | 4c. County of Death Calvert | |
| Funeral Director | 5. Social Security Number 212 36 3934 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug 21 1921 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Calvert | | 10c. City, Town or Location Prince Frederick | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State Maryland | | | 10b. County Calvert | | | 10c. City, Town or Location Prince Frederick | | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 10e. Street and Number 5621 Sandy Point Road | | | 10f. Zip Code 20678 | | |
| 10g. Citizen of What Country? United States | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) secretary | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) secretary | | | 16b. Kind of Business/Industry Dept. of Agriculture | | | 17. Father's Name (First, Middle, Last) Alvin B. Bowen | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Etta Sheckells | | | 19a. Informant's Name/Relationship (Type, Print) Oliver S. Cox- husband | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) sameas # 10 | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Central Cemetery Nov 11 1999 | | | 20c. Location - City or Town, State Barstow Maryland | | |
| 21. Signature of Funeral Service Licensee  | | | 22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. end stage Alzheimer's Disease Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebral Vascular Accident | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | | 28b. Time of injury M | | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier  | | | 29c. License number 045235 | | | 29d. Date signed (Month, Day, Year) 11/9/99 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Catherine I. Brophy, MD 10845 Town Center Blvd #203 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 10 1999 | | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1837

NOV 10 1837

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36298

| | | | | | | | | | | | | | | | | | | | | | | |
|--|--|-------------------------------|---|---|--|---------------------------------|--|--|---|---|----|---------------|---|----|---------------------|---------------|----|--|--|----|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Eva Owens COX | | | | 2. Date of Death Month Day Year November 6, 1999 | | | | 3. Time of Death 4:15 p.m. | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 520 Lower Marlboro Road | | | | 4b. City, Town, or Location of Death Sunderland | | | | 4c. County of Death Calvert | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 220 40 6199 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (in yrs. last birthday) 93 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 9, 1906 | | 9. Birthplace (State or Foreign Country) MD | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | |
| 10a. State MD | | 10b. County Calvert | | 10c. City, Town or Location Sunderland | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| 10e. Street and Number 520 Lower Marlboro Road | | | | 10f. Zip Code 20689 | | | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify white | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker | | | | 16b. Kind of Business/Industry own home | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Daniel Hardesty | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Catherine Drury | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Lorraine C. Henck (daug.) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1340 Appian Dr., Punta Gorda, FL 33950 | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Harmony UM Church | | Date 11-10-99 | | 20c. Location - City or Town, State Owings, MD | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736 | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>ANEMIA</td> <td>Approximate Interval Between Onset and Death MONTHS</td> </tr> <tr> <td>b.</td> <td>COLON CANCER</td> <td>MONTHS</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | ANEMIA | Approximate Interval Between Onset and Death MONTHS | b. | COLON CANCER | MONTHS | c. | | | d. | | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | ANEMIA | Approximate Interval Between Onset and Death MONTHS | | | | | | | | | | | | | | | | | | | |
| | b. | COLON CANCER | MONTHS | | | | | | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number D40370 | | | | | | | | | | | | | | |
| | | | | 29d. Date signed (Month, Day, Year) 11/8/99 | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter Wisniewski, 110 Hospital Drive, Ste 310 Prince Frederick, MD 20678 | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 08 1999 | | | | 32. Registrar's Signature | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

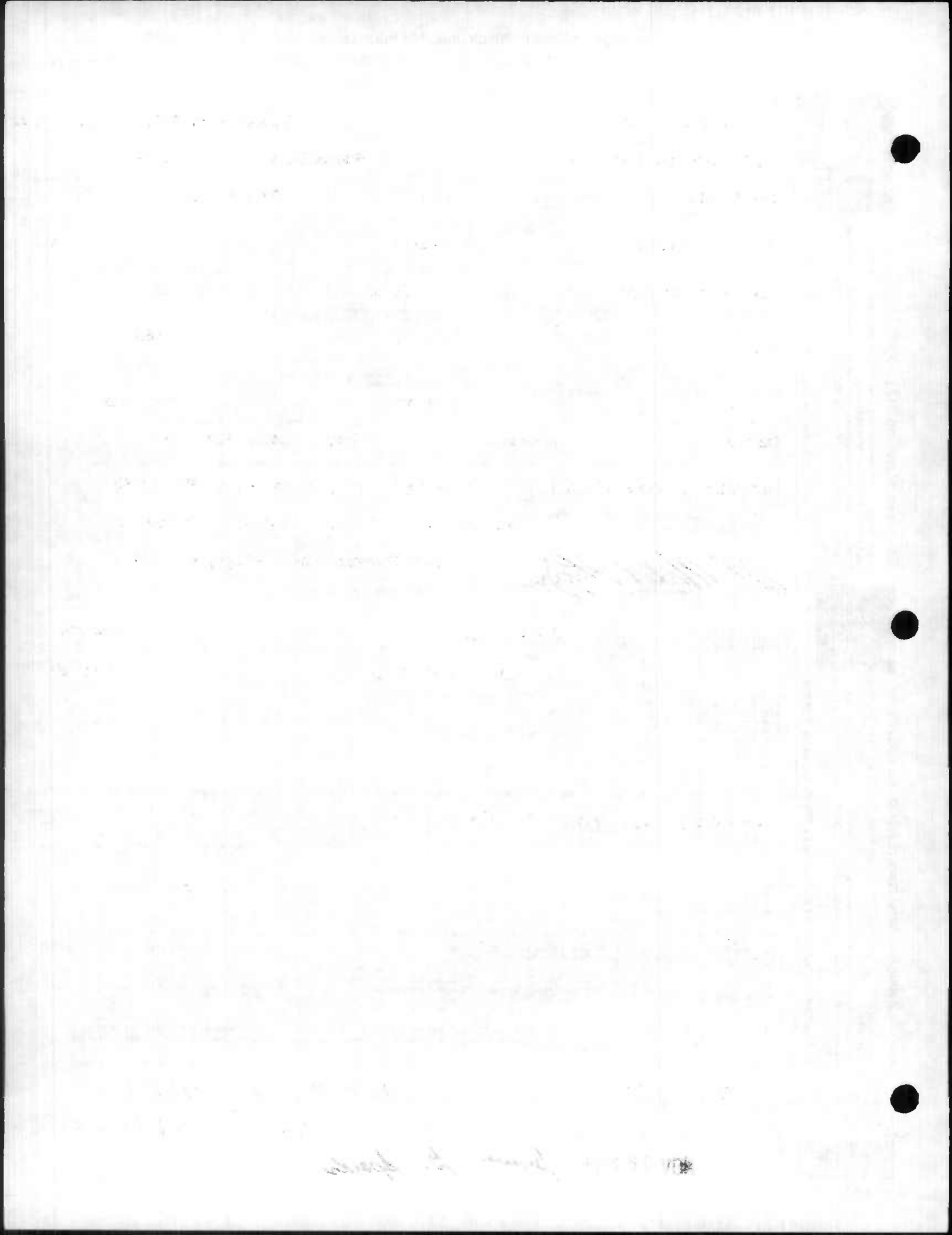
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36299

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John Clifford Damico | | | | 2. Date of Death Month Day Year October 30 1999 | | 3. Time of Death 3:16AM | |
| | 4a. Facility Name (If not institution, give street and number) Oak Crest Village | | | | 4b. City, Town, or Location of Death Parkville | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 060-01-9891 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 89 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 11, 1910 | | 9. Birthplace (State or Foreign Country) New Jersey |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Parkville | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 8820 Walther Blvd. | | | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Marketing Manager | | | 16b. Kind of Business/Industry Telephone Company | |
| 17. Father's Name (First, Middle, Last) Anthony (NMN) Damico | | | | 18. Mother's Name (First, Middle, Maiden Surname) Catherine (NMN) Famulari | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Agatha S. Damico/ wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8820 Walther Blvd., Baltimore, Maryland | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery | | Data 11-02-99 | | 20c. Location - City or Town, State Middletown, New Jersey | | |
| 21. Signature of Funeral Service Licensee <i>Howard K. McComas</i> | | | | 22. Name and Address of Facility Howard K. McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PROSTATE CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ENDSTAGE DEMENTIA | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Howard K. McComas</i> | | | | 29c. License number D25643 | | 29d. Date signed (Month, Day, Year) 10/30/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HP Faulkner MD/8800 Walther Blvd/ Baltimore MD 21234 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 03 1999 | | 32. Registrar's Signature <i>B. Smith</i> | | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

25

DAMICO, JOHN
Baltimore, Maryland 21215-0020

DR

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36300

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GALILEO DI VALENTINO

2. Date of Death

November 4, 1999

3. Time of Death

3:00 Am

4a. Facility Name (If not institution, give street and number)

GOODWILL MENNONITE HOME

4b. City, Town, or Location of Death

GRANTSVILLE

4c. County of Death

GARRETT CO.

Funeral
Director

5. Social Security Number

181-24-1679

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB. 15, 1911

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State
PA10b. County
SOMERSET Co

10c. City, Town or Location

MEYERSDALE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7 NORTH ST.

10f. Zip Code

15552

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

11

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

VALENTINO DIVALENTINO

18. Mother's Name (First, Middle, Maiden Surname)

ANGELA MARIA DICHESSARI

19a. Informant's Name/Relationship (Type, Print)

ROSE LIVENGOOD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

421 THOMAS ST. MEYERSDALE, PA 15552

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

UNION CEMETERY

Date

11-6-99

20c. Location - City or Town, State

MEYERSDALE, PA

21. Signature of Funeral Service Licensee

Donald Lynn Newman

22. Name and Address of Facility

W. R. ARUE FUNERAL HOME, INC.

325 MAIN ST. MEYERSDALE, PA 15552

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Fatal Ventricular Arrhythmia

mins.

Due to (or as a consequence of):

b. Congestive Heart Failure.

5 years

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease.

Diabetes.

Chronic obstructive Lung Disease.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James E. Bertulmo

29c. License number

D 34079

29d. Date signed (Month, Day, Year)

Nov. 4 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James E. Bertulmo Meyersdale, Pa 15552.

31. Date filed (Month, Day, Year)

NOV 08 1999

32. Registrar's Signature

James E. Bertulmo

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

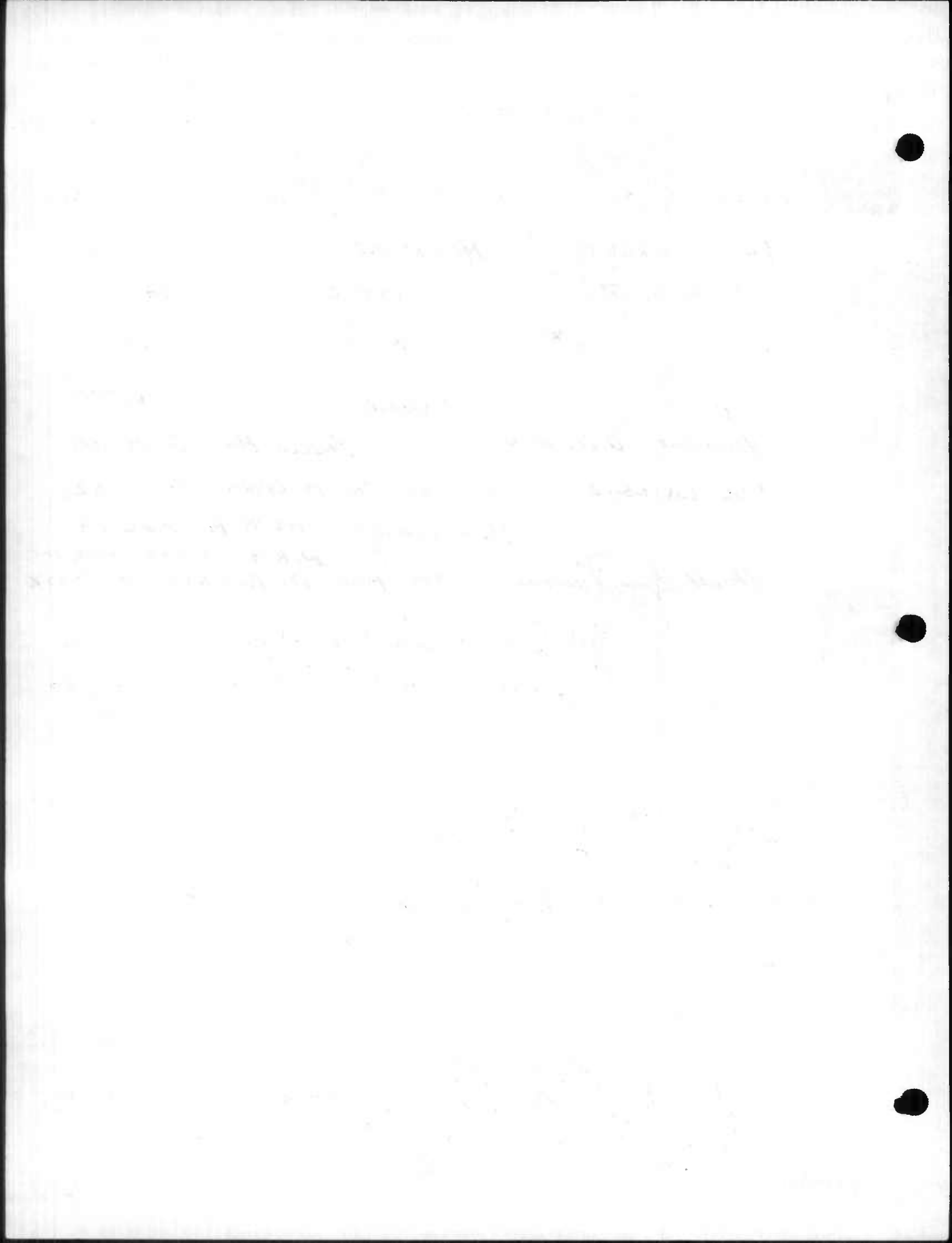
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

7
msState
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36301

| | | | | | | | | | | |
|--|--|--------------------------------|---|---|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Malinda F. Durst | | | | | | 2. Date of Death Month Day Year November 6, 1999 | | 3. Time of Death 11:50 PM | |
| | 4a. Facility Name (If not institution, give street and number) Egle Nursing Home | | | | | | 4b. City, Town, or Location of Death Lonaconing | | 4c. County of Death Allegany | |
| Funeral Director | 5. Social Security Number 213-24-6339 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 93 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 31, 1906 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County Allegany | | 10c. City, Town or Location Barton | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number 23020 Meece Street, N.W. | | | | 10f. Zip Code 21521 | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) Truman Wilt | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Luvenia Bittering | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Lucinda Bowser/Sister | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louna Luo Apt., 312 Main St., Lonaconing, MD 21539 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maple Grove Ch. Cem, Nov. 7, 1999 | | | Date Nov. 7, 1999 | | 20c. Location - City or Town, State Grantsville, MD | | |
| 21. Signature of Funeral Service Licensee <i>Ruth K. Newman</i> | | | | | | 22. Name and Address of Facility Newman Funeral Homes, P.A. 179 Miller St, PO Box 275, Grantsville, MD 21536 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Generalized Arteriosclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 48 hrs. 10 years | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner | | | 29b. Signature and title of certifier <i>L.R. Miles, Jr. M.D.</i> | | | | | | | |
| 29c. License number DD7004 | | | 29d. Date signed (Month, Day, Year) Nov. 7, 1999 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L.R. MILES, JR., M.D., 57 JACKSON ST. LONA CONING MD 21539 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 09 1999 | | | 32. Registrar's Signature <i>Bergman Sparks</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature or initials.

APR 19 1961

99-6363-047

mmmr

unknown #99-252

JOHN L. DAVIS

AMEND#23a,27-28f PER M.E.O. G777 11-22-99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36302

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John L. Davis

2. Date of Death

Month Day Year
October 22, 1999

3. Time of Death

3:55 a.m.

4a. Facility Name (If not institution, give street and number)

Md. Rt. 589, South of Manklin Creek Road

4b. City, Town, or Location of Death

Ocean Pines

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number

6. Sex ☒ M ☐ F

7. Age (In yrs. last birthday)

30

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 13, 1969

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Berlin

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11805 Sinepuxent Rd.

10f. Zip Code

21811

10g. Citizen of What Country?

U.S.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

John Pierce

18. Mother's Name (First, Middle, Maiden Surname)

Clarenda Davis

19a. Informant's Name/Relationship (Type, Print)

Clarenda Davis/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11805 Sinepuxent Rd., Berlin, MD 21811

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Calvary Pentecostal
Church Cemetery

Date

10/30/99

20c. Location - City or Town, State

Bishopville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lewis N. Watson Funeral Home
1618 West Rd., Salisbury, MD 2180123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

MULTIPLE INJURIES

e. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☒ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

10/22/99

28b. Time of
Injury

3:55 A. M

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

MOTOR VEHICLE ACCIDENT

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

STREET

28f. Location (Street and Number or Rural Route Number,
City or Town, State)RT. #589 AND OCEAN PINES
WORCESTER CO., MD.29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David R. Finkler DEPUTY FOR

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

October 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

NOV 02 1999

32. Registrar's Signature

B. Sparks

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
office.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitState
Registrar

1. 15.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36303

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY ELSNER

2. Date of Death

Month Day Year
11 1 99

3. Time of Death

1728

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

217-48-8284

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 16, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

114 Southway Drive

10f. Zip Code

21001

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

In home

17. Father's Name (First, Middle, Last)

Solomon Gosweiler

18. Mother's Name (First, Middle, Maiden Surname)

Emma Smith

19a. Informant's Name/Relationship (Type, Print)

Joan E. Hamilton (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

114 Southway Drive, Havre de Grace, Maryland 21078

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Paul's Lutheran Cemet.

Date

11/4/99

20c. Location - City or Town, State

Aberdeen, Maryland

21. Signature of Funeral Service Licensee

Kenneth B. Cargy

22. Name and Address of Facility

Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Heui Yoo, M.D.

29c. License number

P11795

29d. Date signed (Month, Day, Year)

11/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Heui Yoo, M.D. Univ. of MD Med. Ctr., 22 S. Greene St., Baltimore, MD 21201

State
Registrar

31. Date filed (Month, Day, Year)

NOV 03 1999

32. Registrar's Signature

B. Spindel

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36304

| | | | | | | | |
|---|--|--|---|---|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) George Edward Ellis | | | 2. Date of Death Nov 2, 1999 | | 3. Time of Death 09:18am | |
| | 4e. Facility Name (If not institution, give street and number) Cumberland Nursing Center | | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegany | |
| Funeral Director | 5. Social Security Number 218-16-3699 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 77 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth Feb 3, 1922 | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | | | |
| 10a. State MD | | 10b. County Allegany | | 10c. City, Town or Location Rawlings | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number Bloomingfield Trailer Pk | | | 10f. Zip Code 21557 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retired | | 16b. Kind of Business/Industry Tire Company | | |
| 17. Father's Name (First, Middle, Last) Albert E. Ellis | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lydia M (Burall) | | | |
| 19a. Informant's Name/Relationship (Type, Print) Violet Mae Ellis wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 263; Rawlings, MD 21557 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Restlawn Memorial Gard | | 20c. Location - City or Town, State 11/05 LaVale, MD | | 20d. Date | |
| 21. Signature of Funeral Service Licensee Nicholas J. Scarpelli | | | | 22. Name and Address of Facility Scarpelli Funeral Home P.A. Cumberland, Maryland 21502 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last cerebrovascular Accident Chronic obstructive Pulmonary disease Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cerebrovascular Accident Chronic obstructive Pulmonary disease | | | | | | | Approximate Interval Between Onset and Death 2 days |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and Title of Certifier [Signature] | | | | 29c. License number D33280 | | 29d. Date signed (Month, Day, Year) Nov 5, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunil K. Gupta M.D. 625 Kent Avenue Cumberland MD 21502 | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 05 1999 | | | | 32. Registrar's Signature [Signature] | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Amended # 21, MD, 11/10/99, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36305

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Delano Donald Emerick

2. Date of Death

Month November Day 7, Year 1999

3. Time of Death

12:50 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

220-32-2730

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month May Day 5, Year 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Pennsylvania

10b. County

Somerset

10c. City, Town or Location

Wellersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Rt 160 #14889

10f. Zip Code

15564

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1965

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Acme Milts

17. Father's Name (First, Middle, Last)

Lester Calvin Emerick

18. Mother's Name (First, Middle, Maiden Surname)

Florence Alverta Lowery

19a. Informant's Name/Relationship (Type, Print)

Nellie Emerick, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 155 Wellersburg, PA 15564

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

RestLawn Memorial Gardens

Date

November 10, 1999

20c. Location - City or Town, State

LaVale, Maryland

21. Signature of Funeral Service Licensee

Robert C. Adams

22. Name and Address of Facility

Harvey H. Zeigler Funeral Home

Hyndman, Pennsylvania 15545

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

b. Pulmonary Embolism

Due to (or as a consequence of):

2 weeks

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Endstage renal disease, DM, Peripheral Vascular Dis.
HTN,

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Huma Shakil MD

29c. License number

D 46346

29d. Date signed (Month, Day, Year)

11/9/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Huma Shakil 625 Kent Avenue Cumberland, Maryland 21502

31. Date filed (Month, Day, Year)

NOV 10 1999

32. Registrar's Signature

Benjamin B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

MD

State
Registrar

2071

Handwritten signature

NOV 1 0 1988

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36306

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Leslie Ellis Fishell

2. Date of Death

November 3 1999

3. Time of Death

1228

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

213-24-4933

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 2, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Caroline

10c. City, Town or Location

Federalsburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

26176 Auction Road

10f. Zip Code

21632

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Trucking

17. Father's Name (First, Middle, Last)

Warren Fishell

18. Mother's Name (First, Middle, Maiden Surname)

Mary Lehman Porter

19a. Informant's Name/Relationship (Type, Print)

Doris C. Fishell/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26176 Auction RD, Federalsburg, MD 21632

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hill Crest Cemetery

Date

20c. Location - City or Town, State

11-6 Federalsburg, MD

21. Signature of Funeral Service Licensee

Roman J. Coale

22. Name and Address of Facility

Frampton-Hawkins-Eskow Funeral Home
P.O. Box 43, Federalsburg, MD 2163223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Hyperlipidemia
Prostate Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James Sides

29c. License number

D31376

29d. Date signed (Month, Day, Year)

11-5-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Sides 920 Market St Denton MD 21629

State
Registrar

31. Date filed (Month, Day, Year)

Nov - 5 1999

32. Registrar's Signature

B. Sparks

Leslie Fishell
Baltimore, Maryland 21215-0020Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

11/5/99
10 AM
99 36307

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN DOROTHY GEORGE

2. Date of Death

Month Day Year
November 5 1999

3. Time of Death

10:00 a.m.

4a. Facility Name (If not institution, give street and number)

Chesapeake Woods Center

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral
Director

5. Social Security Number

212-09-7220

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Apr. 6, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

East New Market

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

3317 Woodland Acres Rd.

10f. Zip Code

21631

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (14 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Frederick Himmelhaber

18. Mother's Name (First, Middle, Maiden Surname)

Catherine (unknown)

19a. Informant's Name/Relationship (Type, Print)

Robert Hofmeier - nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

911 Walker St., Aberdeen, MD 21001

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

East New Market Cemetery

Date

11-9-99

20c. Location - City or Town, State

East New Market Md.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Thomas Funeral Home PA
700 Locust St. Cambridge MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction days

Due to (or as a consequence of):

b. Congestive heart failure days

Due to (or as a consequence of):

c. Severe degenerative arthritis, years

Due to (or as a consequence of):

d. iron deficiency Anemia year

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D50987

29d. Date signed (Month, Day, Year)

11/8/99.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmed Nawaz 360 Aurora Blvd Cambridge MD 21613.

31. Date filed (Month, Day, Year)

NOV 09 1999

32. Registrar's Signature

[Signature]

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36308**
Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ESTHER LEE HAM | | | | 2. Date of Death Month Day Year Oct. 26, 1999 | | 3. Time of Death 8:50 PM | | |
| | 4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital | | | | 4b. City, Town, or Location of Death Havre de Grace | | 4c. County of Death Harford | | |
| Funeral Director | 5. Social Security Number 223-30-8001 | | 6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 75 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 6/27/1924 | 9. Birthplace (State or Foreign Country) North Caroli | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State MD | | 10b. County Harford | | 10c. City, Town or Location Forest Hill | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 3124 South Ward Road | | | | 10f. Zip Code 21050 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry | | | |
| 17. Father's Name (First, Middle, Last) William W. Blackburn | | | | 18. Mother's Name (First, Middle, Maiden Surname) Cora Plummer | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Patsy Ham- daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 115, Forest Hill, MD 21050 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Wyatt Family Cemetery | | Date 10/31/99 | | 20c. Location - City or Town, State Lansing, N.C. | | | |
| 21. Signature of Funeral Service Licensee <i>Jeffrey P. Kowalczyk</i> | | | | 22. Name and Address of Facility Harkins F.H. Inc., Delta, PA 17314 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Colon CA w mets Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - Renal Failure - TRACHEOSTOMY - ELECTROLYTE IMBALANCE - ANEMIA - CHF | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>T. Blom</i> MD | | | | | | | |
| 29c. License number 042800 | | 29d. Date signed (Month, Day, Year) 10/27/99 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. Blom 319 S. Union Ave, HDB, MD, 21078 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 04 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | | |

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

PHYSICAL CHEMISTRY

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State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G778 12-13-99 WR.

Certificate of Death

Reg. No.

99 36309

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last) James Robert Hood | | 2. Date of Death Month NOVEMBER Day 14 Year 1999 | | 3. Time of Death 15:55 PM. | |
| 4a. Facility Name (If not institution, give street and number) 2004 BENNETT ROAD | | | 4b. City, Town, or Location of Death ELDERSBURG | | 4c. County of Death CARROLL |
| 5. Social Security Number 219-80-7637 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 38 Yrs. | If Under 1 Year Months 0 Days 0 | If Under 24 Hrs. Hours 0 Min. 0 | 8. Date of Birth (Month, Day, Year) Dec. 25, 1960 |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | 10b. County Carroll | 10c. City, Town or Location Sykesville | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 6508 Sykesville Road | | 10f. Zip Code 21784 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Landscaper | | 16b. Kind of Business/Industry Landscaping | | | |
| 17. Father's Name (First, Middle, Last) Lyman N. Hood | | | 18. Mother's Name (First, Middle, Maiden Surname) Dorothy R. Day | | |
| 19e. Informant's Name/Relationship (Type, Print) Mrs. Cynthia L. Hood (Wife) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6508 Sykesville Road, Sykesville, MD 21784 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Park | | 20c. Location - City or Town, State 11/20/99 Sykesville, MD | |
| 21. Signature of Funeral Service Licensee Brian A. Haight | | 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>CONTACT SHOTGUN WOUND OF HEAD</p> <p>e. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) Found: 11-14-99 | | 28b. Time of Injury Found: M 1-19 | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred SELF INFLICTED WOUND | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND: GARAGE | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2004 BENNETT RD. ELDERSBURG, MD | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier Wayne M. [Signature] | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) NOVEMBER 15, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY R. [Signature] 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 16 1999 | | 32. Registrar's Signature [Signature] | | | |

[Handwritten signature]

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)
RUTH CARTER HOLLAND

2. Date of Death
Month **11** Day **8** Year **99**

3. Time of Death
1625

4a. Facility Name (If not institution, give street and number)
Atlantic General Hospital

4b. City, Town, or Location of Death
Berlin

4c. County of Death
Worcester

5. Social Security Number
216-40-3774

6. Sex
☐ M ☒ F

7. Age (In yrs. last birthday)
82 Yrs.

8. Date of Birth (Month, Day, Year)
7/7/17

9. Birthplace (State or Foreign Country)
PA

10a. State
MD

10b. County
Worcester

10c. City, Town or Location
Berlin

10d. Inside City Limits
☒ Yes ☐ No

10e. Street and Number
300 S. Main St.

10f. Zip Code
21811

10g. Citizen of What Country?
USA

11. Marital Status
☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.
Specify: **White**

15. Decedent's Education (Specify only highest grade completed)
12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Librarian

16b. Kind of Business/Industry
Public Library

17. Father's Name (First, Middle, Last)
Theodore Nelson Carter

18. Mother's Name (First, Middle, Maiden Surname)
Mary Stephen

19a. Informant's Name/Relationship (Type, Print)
Nancy Holland/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
300 S. Main St. Berlin, MD 21811

20a. Method of Disposition
☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)
Evergreen Cemetery

20c. Location - City or Town, State
11/11/99 Berlin, MD

21. Signature of Funeral Service Licensee
[Signature]

22. Name and Address of Facility
**Burbage Funeral Home
108 William St. Berlin, MD 21811**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Cardiac Arrest
Due to (or as a consequence of):
Severe Ischemic Cardiomyopathy
Myocardial infarct

23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Metastatic Breast Cancer
Congestive Heart Failure

23c. Did tobacco use contribute to the cause of death?
☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?
☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?
☐ Yes ☒ No

25. Was case referred to medical examiner?
☐ Yes ☒ No

26. Place of Death (Check only one)
Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA
Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death
☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury
M

28c. Injury at Work?
☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier
[Signature]

29c. License number
0-0048221

29d. Date signed (Month, Day, Year)
11/9/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Letitia M. Solana, MD Atlantic General Hospital, Berlin MD

31. Date filed (Month, Day, Year)
NOV 10 1999

32. Registrar's Signature
[Signature]

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Robert Lynn Hale | | 2. Date of Death Month November Day 04 Year 1999 | | 3. Time of Death 8:24 PM. | |
| 4a. Facility Name (If not institution, give street and number) Memorial Hospital | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegany | |
| 5. Social Security Number 215-48-8078 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 52 Yrs. | |
| 8. Date of Birth (Month, Day, Year) April 18, 1947 | | 9. Birthplace (State or Foreign Country) Maryland | | 10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10a. State MD | | 10b. County Allegany | | 10c. City, Town or Location Cumberland | |
| 10d. Street and Number 330 Cumberland St. | | 10e. Zip Code 21502 | | 10f. Citizen of What Country? United States | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accounting | |
| 16b. Kind of Business/Industry Accountant | | 17. Father's Name (First, Middle, Last) John Issac Hale | | 18. Mother's Name (First, Middle, Maiden Surname) Frances McGee | |
| 19a. Informant's Name/Relationship (Type, Print) Helen Jean Hale / sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 Warren St. Cumberland, MD 21502 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sunset Memorial Park | | 20c. Location - City or Town, State 11/8/99 Cumberland, MD | |
| 21. Signature of Funeral Service Licensee Dale L. Merritt | | 22. Name and Address of Facility Merritt-Adams Funeral Home, P.A. 404 Decatur St. Cumberland, MD 21502 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) COMPLICATED BY CAFFEINE INTOXICATION | | | | | |
| Due to (or as a consequence of): DILATED CARDIOMYOPATHY | | | | | |
| Due to (or as a consequence of): | | | | | |
| Due to (or as a consequence of): | | | | | |
| Due to (or as a consequence of): | | | | | |
| Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day, Year) 11/4/1999 | | | | | |
| 28b. Time of Injury 6:25 P M | | | | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 28d. Describe how injury occurred unknown | | | | | |
| 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) home | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) 330 Cumberland St. Allegany County, Md. | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier Robert A. Koroluk | | | | | |
| 29c. License number O.C.M.E. | | | | | |
| 29d. Date signed (Month, Day, Year) November 5, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert A. Koroluk 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 10 1999 | | | | | |
| 32. Registrar's Signature B Sparks | | | | | |

NOV 1 0 1968

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36312

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Irene Elizabeth Hoover | | | | 2. Date of Death Month Day Year November 4 1999 | | 3. Time of Death 6:03 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 212-24-1050 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 73 Yrs. | | 8. Date of Birth (Month, Day, Year) 12/23/1925 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 1 Brett Ct. Baltimore, MD | | 10f. Zip Code 21221 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeper | | 16b. Kind of Business/Industry Home | | 17. Father's Name (First, Middle, Last) Lester L. O'Neal | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Angela Ann Greise | | 19a. Informant's Name/Relationship (Type, Print) Joseph R. Hoover / son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15333 Brice Hollow Rd. Cumberland, MD 21502 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) SS Peter & Paul Cemetery | | 20c. Location - City or Town, State Cumberland, MD | | 21. Signature of Funeral Service Licensee Dale L. Merritt | | 22. Name and Address of Facility Merritt-Adams Funeral Home, P.A. 404 Decatur St. Cumberland, MD 21502 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Arrhythmia Due to (or as a consequence of): Severe Aortic Stenosis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Type II Diabetes Mellitus, Coronary Artery Disease, Congestive Heart Failure, Hypertension | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Dale L. Merritt MD | | 29c. License number D 38 754 | | 29d. Date signed (Month, Day, Year) November 5, 1999 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Malik Waseem 9000 Franklin Square Drive Baltimore, MD 21237 | | 31. Date filed (Month, Day, Year) NOV 10 1999 | | 32. Registrar's Signature Dale L. Merritt | | | |

ORIGINAL

NOV 10 1988

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36313

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HELEN SUZANNE HAMMOND | | | | 2. Date of Death Month Day Year NOVEMBER 2, 1999 | | 3. Time of Death 5:40 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) BERLIN NURSING & REHABILITATION CENTER | | | | 4b. City, Town, or Location of Death BERLIN | | 4c. County of Death WORCESTER | |
| Funeral Director | 5. Social Security Number 033-09-0277 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) August 15, 1918 | |
| | 9. Birthplace (State or Foreign Country) Massachusetts | | 10a. State Maryland | | 10b. County Worcester | | 10c. City, Town or Location Berlin | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 9715 Healthway Drive | | 10f. Zip Code 21811 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 1 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Wireman | | 16b. Kind of Business/Industry Western Electric | | 17. Father's Name (First, Middle, Last) Thomas Joseph Wilman | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Florence Anderson | | 19a. Informant's Name/Relationship (Type, Print) Beverly Ann Latham/Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34818 Old Ocean City Rd., Pittsville, MD 21850 | | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory | | 20c. Location - City or Town, State Salisbury, MD | | 21. Signature of Funeral Service Licensee MO1051 David H. Thompson | | 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial infarct Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Coronary sclerosis Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death minutes yes years | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Dr. Federico Arthes | |
| | 29c. License number D02026 | | 29d. Date signed (Month, Day, Year) 11-2-99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. FEDERICO ARTHES, 46 TEAL CIRCLE, BERLIN, MD. 21811 410-641-4400 | | 31. Data filed (Month, Day, Year) NOV 04 1999 | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature B. Sparks | | 33. Registrar's Signature | | 34. Registrar's Signature | | 35. Registrar's Signature | |

ORIGINAL

Photo of the
company (Lester, Brown,
and others)

Photo of the
company (Lester, Brown,
and others)

Photo of the
company (Lester, Brown,
and others)

Photo of the
company (Lester, Brown,
and others)

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36314

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KATHLEEN G. JOHNSTON

2. Date of Death

Month Day Year
NOV 3 1999

3. Time of Death

4:45 PM

4a. Facility Name (If not institution, give street and number)

GILCREST HOSPICE CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

219-03-9510

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JULY 12, 1917

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3403 ACTON ROAD

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

LUTHER GROSH

18. Mother's Name (First, Middle, Maiden Surname)

B. PAULINE GARDNER

19a. Informant's Name/Relationship (Type, Print)

MARY JO LAND/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3403 ACTON ROAD, BALTIMORE, MD 21234

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)NOV 6, 1999
HILLCREST MEMORIAL PARK

20c. Location - City or Town, State

CUMBERLAND, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HAVER FUNERAL HOME
1302 NATIONAL HWY, LAVALE, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)e. RENAL FAILURE

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 MONTHS

b. ATHEROEMBOLISM

Due to (or as a consequence of):

10 YEARS

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastc. ATHEROSCLEROTIC PERIPHERAL VASCULAR DISEASE

Due to (or as a consequence of):

30 YEARS

d. HYPERLIPIDEMIA

Due to (or as a consequence of):

40 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD; HYPERTENSIONCONGESTIVE CARDIAC FAILURE

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

HOSPICE

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 51228

29d. Date signed (Month, Day, Year)

NOV 04/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAMAN A GOPALAN MD

EAST ROLLING CROSSROADS #159 BALTIMORE
MD 21228State
Registrar

31. Date filed (Month, Day, Year)

NOV 09 1999

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
Johnston, Kathleen
11/3/99 4:45 PM
permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Handwritten signature

PROJ C 0 NOV

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36315

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Clementine Jones

2. Date of Death

October 26, 1999

3. Time of Death

1:00 AM

4a. Facility Name (If not institution, give street and number)

603 Caroline Apartments

4b. City, Town, or Location of Death

Denton

4c. County of Death

Caroline

Funeral
Director

5. Social Security Number

202-18-8891

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 21, 1911

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

603 Caroline Apartments

10f. Zip Code

21629

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Caucasian

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Cashier/Manager

16b. Kind of Business/Industry

Antique Store

17. Father's Name (First, Middle, Last)

Willard William Cohee

18. Mother's Name (First, Middle, Maiden Surname)

Clementine Mabel Fountain

19a. Informant's Name/Relationship (Type, Print)

Harriet L. Losey Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

533 Marilyn Drive, East Tawas, Michigan 48730

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Concord Cemetery

Date

10/29/99 near Denton, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensed

Raudolph P. Moore

22. Name and Address of Facility

Moore Funeral Home, P.A.

12 South Second Street, Denton, Maryland 21629

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)e. HYPERTENSIVE CARDIOVASCULAR DISEASE 20 YRS
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician:2 ☒ Medical Examiner:To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of certifier

Christian E. Jensen MD

29c. License number

D14664

29d. Date signed (Month, Day, Year)

29 Oct. 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Christian E. Jensen, M.D., PO Box 690, Denton, Maryland 21629

State
Registrar

31. Date filed (Month, Day, Year)

NOV - 1 1999

32. Registrar's Signature

Benita B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

mmmr

Edward Kita

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36316

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edward J. Kita | | | | | | 2. Date of Death Month Day Year October 29, 1999 | | 3. Time of Death 4:20 p.m. | |
| | 4a. Facility Name (If not institution, give street and number) Memorial Hospital | | | | | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegany | |
| Funeral Director | 5. Social Security Number 186-32-9580 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 56 Yrs. | | 8. Date of Birth (Month, Day, Year) 12/18/1942 | | 9. Birthplace (State or Foreign Country) Pennsylvania | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Pa. | | 10b. County Montgomery | | 10c. City, Town or Location King of Prussia | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 363 East Valley Forge Road | | | | 10f. Zip Code 19406 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager | | | 16b. Kind of Business/Industry Bell Atlantic Phone | | |
| | 17. Father's Name (First, Middle, Last) Edward F. Kita | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Justinia B. Bodnarsky | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Janet T. Kita/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 363 E. Valley Forge Road King of Prussia, Pa. 19406 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Augustine Cemetery | | 20c. Date 11/3/1999 | | 20d. Location - City or Town, State Upper Merion Twp., PA. | | | |
| | 21. Signature of Funeral Service Licensee Jeffrey N. Zumbro | | | | 22. Name and Address of Facility J.N. Zumbro Funeral Home 6028 Sykesville Road Eldersburg, MD. 21784 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| State Registrar | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) 10/29/99 | | 28b. Time of Injury 3:55 PM | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Subject motor vehicle struck by vehicle | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) roadway | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Long Mountain in Allegheny County, Maryland | | | |
| | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier Theodore M. King | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) November 1, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 02 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transfer

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State of Maryland / Department of Health and Mental Hygiene 99 36317
Certificate of Death Reg. No.

Reg. No.

DMMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36318

| | | | | | | | | |
|--|--|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WILLIAM G. KRIEGER | | | | 2. Date of Death Month NOVEMBER Day 1 Year 99 | | 3. Time of Death 9:45AM | |
| | 4a. Facility Name (If not institution, give street and number) CAROLINE NURSING HOME, INC. | | | | 4b. City, Town, or Location of Death DENTON | | 4c. County of Death CAROLINE | |
| Funeral Director | 5. Social Security Number 218-12-1368 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 18, 1921 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Caroline | | 10c. City, Town or Location Federalsburg | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 619 Liberty Road | | | | 10f. Zip Code 21632 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 43-45 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 Collega (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager | | 16b. Kind of Business/Industry Shoe Store | | |
| 17. Father's Name (First, Middle, Last) William F. Krieger | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lillie Plutschak | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Betty B. Krieger/Spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 619 Liberty Road, Federalsburg, MD 21632 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hill Crest Cemetery | | Data 11/5 | | 20c. Location - City or Town, State Federalsburg, MD | | |
| 21. Signature of Funeral Service Licensee Mikhail F. Eskov | | | | 22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. hepatic Cirrhosis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death YRS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier James Sides | | 29c. License number D31376 | | 29d. Date signed (Month, Day, Year) 11-1-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Sides 920 Market St Denton MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV - 5 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

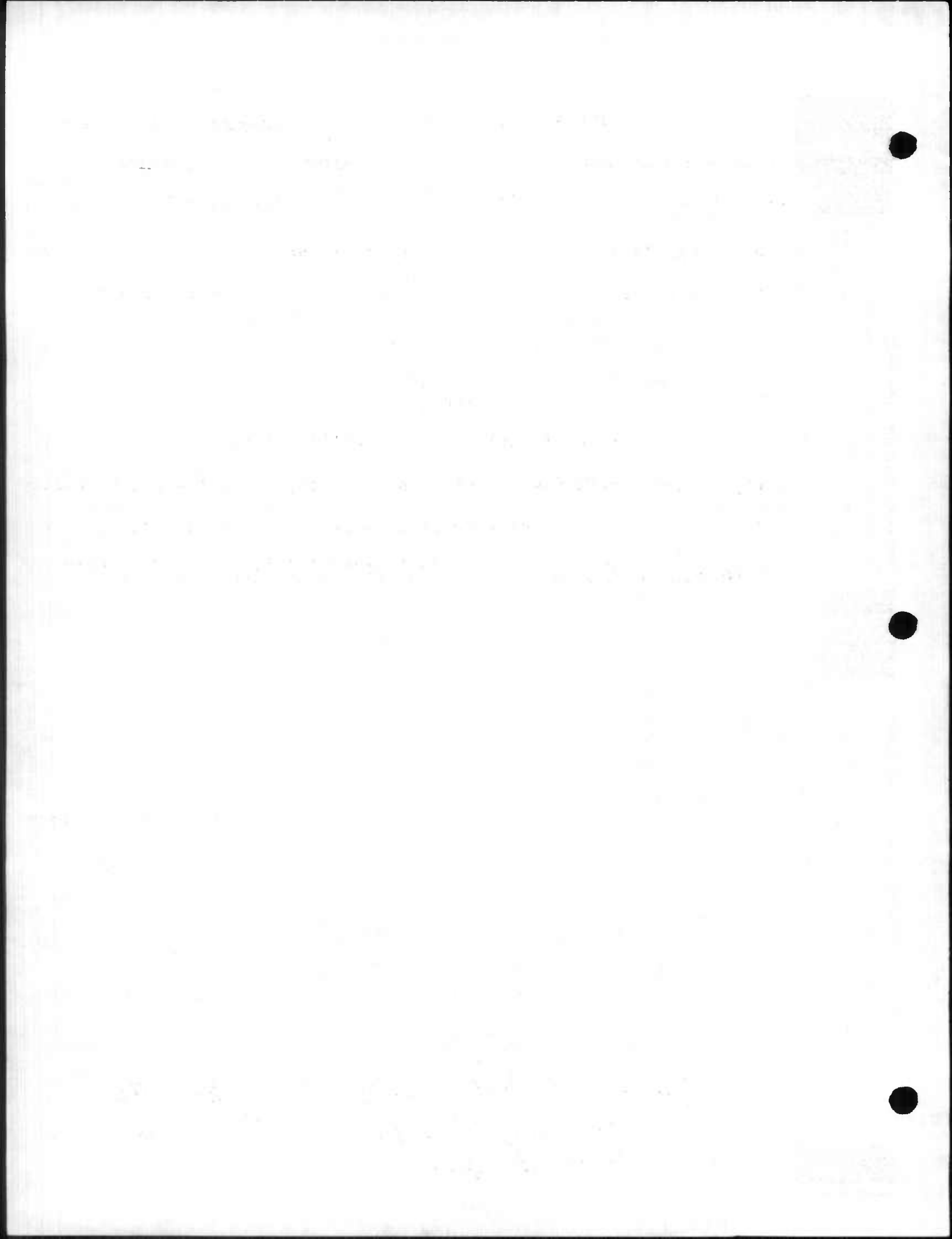
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36319

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDNA YOUNG LEGAN

2. Date of Death

November 7, 1999

3. Time of Death

2:20PM

4a. Facility Name (If not institution, give street and number)

6976 ARCHIE DENNIS ROAD

4b. City, Town, or Location of Death

PARSONSBURG

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

220-32-2093

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MARCH 14, 1934

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

PA

10b. County

LEHIGH

10c. City, Town or Location

OREFIELD

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1334 CATHEDRAL LANE

10f. Zip Code

18069

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

LICENSED VOCATIONAL NURSE

16b. Kind of Business/Industry

HEALTH CARE

17. Father's Name (First, Middle, Last)

BERKLEY ASHTON YOUNG

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH BYRD

19a. Informant's Name/Relationship (Type, Print)

ELIZABETH SMULLEN/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1334 CATHEDRAL LANE, ALLENTOWN, PA 18069

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CAMBRIDGE CREMATORY

Date

11/8/99

20c. Location - City or Town, State

CAMBRIDGE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ZELLER FUNERAL HOME, P. O. BOX 3171,
1212 OLD OCEAN CITY ROAD, SALISBURY, MD 2180223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Atherosclerosis

Due to (or as a consequence of):

b.

Coronary Artery Disease

Due to (or as a consequence of):

c.

Ischemic Cardiomyopathy

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

years

years

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?
☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify) Daughter's residence

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D36783

29d. Date signed (Month, Day, Year)

11-8-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffery Etherton, M.D. PRMC Salisbury, Md. 21801

31. Date filed (Month, Day, Year)

NOV 09 1999

32. Registrar's Signature

B. Sparks

State
RegistrarBaltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36320

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edna Carolyn Legacy | | | | 2. Date of Death Month Day Year November 1 1999 | | 3. Time of Death 5:30 PM | |
| | 4a. Facility Name (If not institution, give street and number) Shore Nursing & Rehabilitation Center | | | | 4b. City, Town, or Location of Death Denton | | 4c. County of Death Caroline | |
| Funeral Director | 5. Social Security Number 090-07-0369 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 83 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Jan 31, 1916 | 9. Birthplace (State or Foreign Country) New York |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Caroline | | 10c. City, Town or Location Henderson | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 121 Bee Tree Rd | | | | 10f. Zip Code 21640 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker | | 16b. Kind of Business/Industry own home | | | |
| | 17. Father's Name (First, Middle, Last) Joseph May | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marie Schubert | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Robert V. Legacy Sr/ husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 Bee Tree Rd Henderson, Maryland 21640 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Eastern Shore Veterans Cemetery | | Date Nov 4, 1999 | | 20c. Location - City or Town, State Hurlock, Maryland | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Fleegle & Helfenbein Funeral Home PO Box 160 Greensboro, Maryland 21639 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Cerebrovascular accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Anemia Coagulopathy | | | | | | | Approximate Interval Between Onset and Death 5d 6mo |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia Coagulopathy | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| State Registrar | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how Injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number D35284 | | 29d. Date signed (Month, Day, Year) 11/01/99 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ANDREA AELON MD 219 S. Washington St Eastern MD 21601 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV - 4 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | |

Baltimore, Maryland 21215-0020

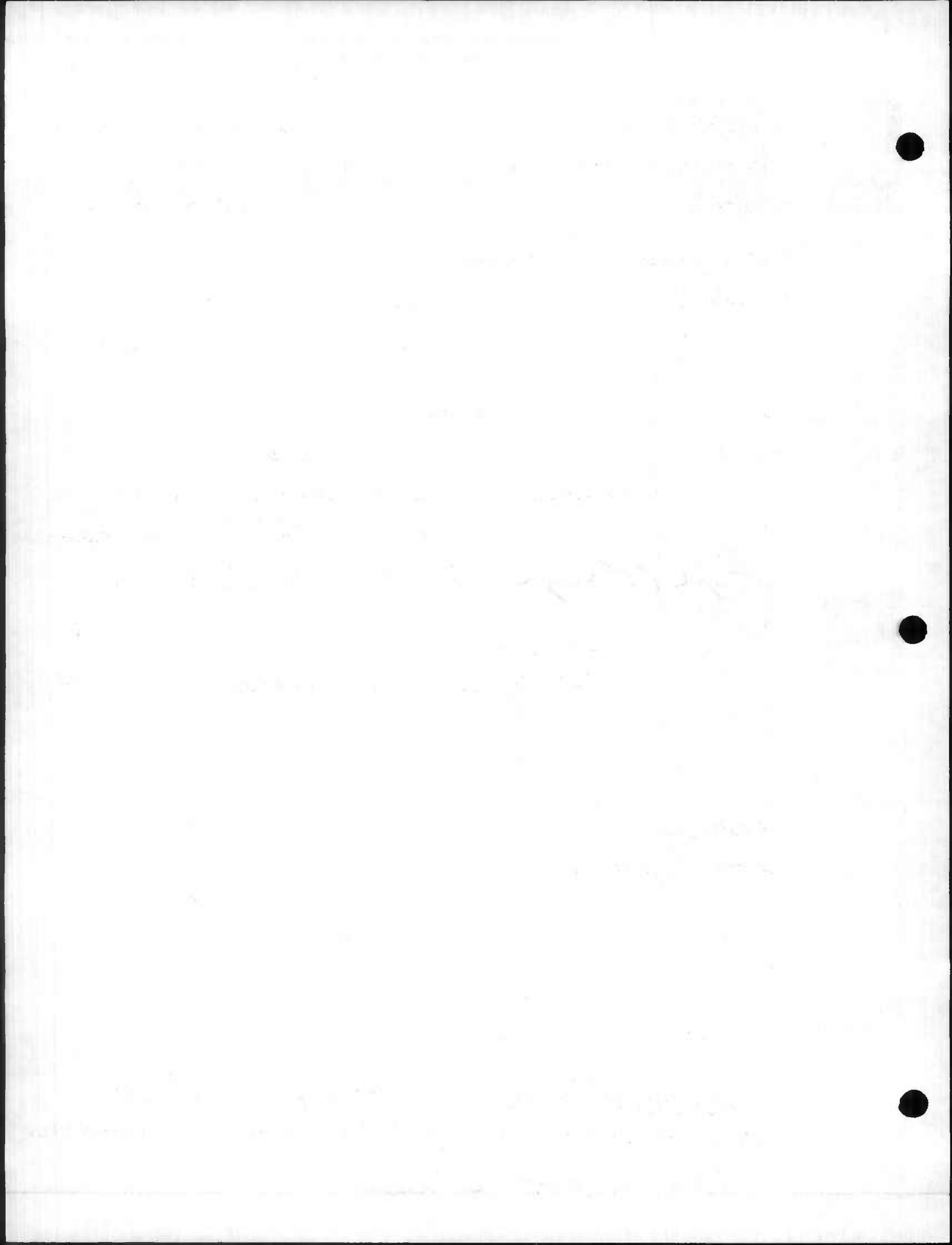
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36321**
Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|---|--|--|--|---|-------------------------------------|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mark R Layton | | | | 2. Date of Death Month 10 Day 27 Year 99 | | | | 3. Time of Death 2:30p | | |
| | 4a. Facility Name (If not Institution, give street and number) ATLANTIC GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death BERLIN | | | | 4c. County of Death WORCESTER | | |
| Funeral Director | 5. Social Security Number 212-82-2018 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 38 Yrs. | | 8. Date of Birth (Month, Day, Year) | | 9. Birthplace (State or Foreign Country) WASHINGTON, DC | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MARYLAND | | 10b. County WORCESTER | | 10c. City, Town or Location OCEAN CITY | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 208 N. PHILADELPHIA AVE. APT. L | | | | 10f. Zip Code 21842 | | | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER | | | | 16b. Kind of Business/Industry RESTAURANT SUPPLIES | | | |
| 17. Father's Name (First, Middle, Last) FRED DURWOOD LAYTON | | | | 18. Mother's Name (First, Middle, Maiden Surname) SHIRLEY ALFORD | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) SHIRLEY A. LAYTON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 ROLLING RD WYNNEWOOD, PA 19096 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) LAYTON FAMILY CEMETERY | | 20c. Date 11-2-99 | | 20d. Location - City or Town, State EDENTON, NC | | | | | |
| 21. Signature of Funeral Service Licensee <i>Robert W. Adams Jr.</i> | | | | 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute renal failure Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): c. alcoholic hepatitis Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number 10058612 | | | | 29d. Date signed (Month, Day, Year) 10/29/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 124 N. Main St. Berlin MD 21811 Andrea Hoffman | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 02 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

DHMH 16 Rev 6/95

DOB 3/26/61
SS 212-82-2018
Baltimore, Maryland 21215-0020Layton, Mark R.
Date/TIME 10/29/99 1430

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36322**
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|---|---|---------------------------------|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedant's Name (First, Middle, Last) Pearl (nmn) Mitzel | | | | 2. Date of Death Month October Day 31 , Year 1999 | | | | 3. Time of Death 7:00 PM | |
| | 4a. Facility Name (If not institution, give street and number) 3328 Hughes Road | | | | 4b. City, Town, or Location of Death Darlington | | | | 4c. County of Death Harford | |
| Funeral Director | 5. Social Security Number 218-32-3539 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 64 Yrs. | | 8. Date of Birth (Month, Day, Year) May 25, 1935 | | 9. Birthplace (State or Foreign Country) N. Carolina | |
| | Usual Residence of Decedent | | | | 10a. State Maryland | | | | 10b. County Harford | |
| To Be Completed by Funeral Director | 10c. City, Town or Location Darlington | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| | 10e. Street and Number 3328 Hughes Road | | | | 10f. Zip Code 21034 | | | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedant Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) | | | | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress | | | | 16b. Kind of Business/Industry Clothing Manufacturer | |
| | 17. Father's Name (First, Middle, Last) George Lee Mahaffey | | | | 18. Mother's Name (First, Middle, Maiden Surname) Odas Dora Jones | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Richard Martin Mitzel/ Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3328 Hughes Rd., Darlington, MD 21034 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Darlington Cemetery | | 20c. Location - City or Town, State 11-4-99 Darlington, Maryland | | | | | |
| | 21. Signature of Funeral Service Licensee <i>Charles A. Enge</i> | | | | 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 | | | | | |
| | 23a. Part I. Enter the disease, or combination that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC BREAST CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 9 YEARS | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>John P. Edwards, M.D.</i> | | | | 29c. License number 231775 | | 29d. Date signed (Month, Day, Year) NOVEMBER 2, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John P. Edwards, M.D. 3112 BELAIR ROAD FAUSTON, MARYLAND 21047 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 03 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36323
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ALICE RITA MAGARDO | | | | 2. Date of Death Month Day Year NOVEMBER 3 1999 | | | | 3. Time of Death 4:55 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) MARINER HEALTH OF FOREST HILL | | | | 4b. City, Town, or Location of Death FOREST HILL | | | | 4c. County of Death HARFORD | |
| Funeral Director | 5. Social Security Number 020-01-6783 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 91 Yrs. | | 8. Date of Birth (Month, Day, Year) July 11, 1908 | | 9. Birthplace (State or Foreign Country) Massachusetts | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Harford | | 10c. City, Town or Location Fallston | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 1904 Angleside Rd. | | | | 10f. Zip Code 21047 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary / Bookkeeper | | | | 16b. Kind of Business/Industry Retail | |
| | 17. Father's Name (First, Middle, Last) Antonio Padua Silva | | | | 18. Mother's Name (First, Middle, Maiden Surname) Francisca Alice Silveira | | | | | |
| To Be Completed by Funeral Director | 19a. Informant's Name/Relationship (Type, Print) Robert F. Magardo/ Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1904 Angleside Rd., Fallston, MD 21047 | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp. | | 20c. Location - City or Town, State 11-5-99 Towson, Maryland | | | | | |
| | 21. Signature of Funeral Service Licensee <i>Holly K. McComas</i> | | | | 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>cerebral vascular accident</i> Due to (or as a consequence of): | | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | |
| Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>alcohol consumption</i> | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier <i>David S. Dunn</i> | | | | | 29c. License number D32295 | | | 29d. Date signed (Month, Day, Year) November 3, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>David S. Dunn 615 W. MacPha. 1</i> | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 05 1999 | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36324**

Amend Item# 5 HCHD 11/16/99 BH **Certificate of Death**

Reg. No.

| | | | | | |
|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>William Neal McFaul</i> | | 2. Date of Death Month <i>November</i> Day <i>8</i> Year <i>1999</i> | | 3. Time of Death <i>9:04 pm</i> |
| | 4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical Systems</i> | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | 4c. County of Death ----- |
| Funeral Director | 5. Social Security Number <i>212-34-2567</i> | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>61</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) <i>Dec. 2, 1937</i> | | 9. Birthplace (State or Foreign Country) <i>Maryland</i> | | |
| Usual Residence of Decedent | | | | | |
| 10a. State <i>Maryland</i> | | 10b. County <i>Harford</i> | | 10c. City, Town or Location <i>Bel Air</i> | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number <i>1005 Lees Wood Road</i> | | | 10f. Zip Code <i>21014</i> | | 10g. Citizen of What Country? <i>USA</i> |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>Vietnam</i> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: _____ | |
| 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>5+</i> College (1-4 or 5+) <i>5+</i> | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Administrator</i> | | 16b. Kind of Business/Industry <i>Municipal Government</i> |
| 17. Father's Name (First, Middle, Last) <i>William Neal McFaul, Jr.</i> | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Grace (nmn) Sumpter</i> | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Iris W. McFaul / Wife</i> | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1005 Lees Wood Road, Bel Air, MD 21014</i> | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____ | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Bel Air Memorial Gardens</i> | | 20c. Location - City or Town, State <i>11-13-99 Bel Air, Maryland</i> | |
| 21. Signature of Funeral Service Licensee <i>Hester A. Hester</i> | | | 22. Name and Address of Facility <i>McComas Funeral Home, P.A. 50 W. Broadway St., Bel Air, MD 21014</i> | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. <i>Biventricular Failure</i> | | | Approximate Interval Between Onset and Death <i>45 min</i> |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. <i>Coronary Artery Bypass</i> | | | <i>4 hours</i> |
| | | c. <i>Coronary Artery Disease</i> | | | <i>3 months</i> |
| | | d. _____ | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension, Hyperlipidemia</i> | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <i>M</i> | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>Chun-Rong</i> Resident Surgeon | | 29c. License number <i>D47930</i> | | 29d. Date signed (Month, Day, Year) <i>11/8/99</i> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Charles S. Drummond, III, MD 225 Greene Street Baltimore Maryland 21201</i> | | | | | |
| 31. Date filed (Month, Day, Year) <i>NOV 12 1999</i> | | 32. Registrar's Signature <i>B. Sparks</i> | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36325

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|---|--|--|--|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Martin Joseph Matsko Sr. | | | | | | 2. Date of Death Month November Day 1 Year 1999 | | 3. Time of Death 4:18pm | | |
| | 4a. Facility Name (If not institution, give street and number) Carroll County General Hospital | | | | | | 4b. City, Town, or Location of Death Westminster | | 4c. County of Death Carroll | | |
| Funeral Director | 5. Social Security Number 199-28-4785 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 60 Yrs. | | 8. Date of Birth (Month, Day, Year) June 25 1939 | | 9. Birthplace (State or Foreign Country) Pa. | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md | | 10b. County Carroll | | 10c. City, Town or Location Woodbine | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 7404 Old Washington Road | | | | 10f. Zip Code 21797 | | 10g. Citizen of What Country? USA | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) +7 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) medical sciences liason | | | | 16b. Kind of Business/Industry pharmaceuticals | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) John Matsko | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Johanna Maylath | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Patricia K. Matsko (spouse) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7404 Old Washington Rd., Woodbine, Md 21797 | | | | | | |
| | 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial | | 20c. Location - City or Town, State 11-5-99 Sykesville, Md | | | | | | |
| | 21. Signature of Funeral Service Licensee ► Paige Haight Herbert | | | | 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195, Sykesville, Md 21784 | | | | | | |
| Physician /Medical Examiner | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CORONARY ARTERY DISEASE | | | | | | | | Approximate Interval Between Onset and Death 12 YEARS | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): b. c. d. | | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier ► Kenneth J. Johnson M.D. | | | | 29c. License number 017040 | | 29d. Date signed (Month, Day, Year) 11/1/99 | | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) HAYWARD, LANHAM, MD 215 WASHINGTON RD WESTMINSTER MD 21157 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 03 1999 | | 32. Registrar's Signature ► B. Sparks | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36326

AMEND#23a 27-28F PER M.E.O. G777.11-22-99 J.A.

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|---------------------------|--|---|---|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) William John Meekins | | | | | 2. Date of Death Month Day Year November 04 1999 | | 3. Time of Death 1:18 PM. | | | |
| | 4a. Facility Name (If not institution, give street and number) Dorchester General Hospital | | | | | 4b. City, Town, or Location of Death Cambridge | | 4c. County of Death Dorchester | | | |
| Funeral Director | 5. Social Security Number 217-36-1999 | | 6. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/> | | 7. Age (In yrs. last birthday) 61 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct 3, 1938 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Dorchester | | 10c. City, Town or Location Fishing Creek | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 2716 Hoopers Island Road | | | | 10f. Zip Code 21634 | | 10g. Citizen of What Country? US | | | | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waterman | | | 16b. Kind of Business/Industry Seafood | | | | |
| 17. Father's Name (First, Middle, Last) William Kinnamon Meekins | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Venia Meekins | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Teresa M. Tolley Niece | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Vue de L'eau Street Cambridge, Maryland 21613 | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hosier Churchyard | | Date 11/10/99 | | 20c. Location - City or Town, State Fishing Creek, Maryland | | | |
| 21. Signature of Funeral Service Licensee | | | | | 22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 | | | | | | |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE AND ALCOHOL INTOXICATION COMPLICATED BY ENVIRONMENTAL HYPOTHERMIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24e. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) FOUND 11-4-99 | | 28b. Time of Injury 11:30 AM | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred EXPOSED TO COLD ENVIRONMENT | | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND: HOUSE | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2716 HOOPERS ISLAND RD. FISHING CREEK, MARYLAND | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier | | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) November 5, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARSHALL D. KORON 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 09 1999 | | | 32. Registrar's Signature | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36327

Francis M McKenzie

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Francis S. McKenzie | | 2. Date of Death Month November Day 6 Year 99 | | 3. Time of Death 7:00 AM | |
| 4a. Facility Name (If not institution, give street and number) 869 Gephart Drive | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegany | |
| 5. Social Security Number 214-07-2521 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | |
| 8. Date of Birth (Month, Day, Year) Sep 30, 1909 | | 9. Birthplace (State or Foreign Country) MD | | | |
| 10a. State MD | | 10b. County Allegany | | 10c. City, Town or Location Cumberland | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 869 Gephart Drive | | 10f. Zip Code 21502 | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) employee | | 16b. Kind of Business/Industry Textile | | 17. Father's Name (First, Middle, Last) George J. McKenzie | |
| 18. Mother's Name (First, Middle, Maiden Surname) Mary (Hershberger) | | 19a. Informant's Name/Relationship (Type, Print) Annabelle Butler daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 98 LaVale Blvd.; LaVale MD 21502 | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Memorial Par11/10 Cumberland, MD | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee Nicholas J. Langell | | 22. Name and Address of Facility Scarpe Hall Funeral Home P.A. Cumberland, Maryland 21502 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death 1 minute 10 years | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Donald F. Mangert | |
| 29c. License number 009231 | | 29d. Date signed (Month, Day, Year) November 6 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donald F. Mangert 11600 Bedford Road Cumberland Maryland 21502 | |
| 31. Date filed (Month, Day, Year) NOV 09 1999 | | 32. Registrar's Signature Sparks | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36328

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

L. MILDRED MITCHELL

2. Date of Death

Nov. 10, 1999

3. Time of Death

2310

4a. Facility Name (If not institution, give street and number)

6761 Eldorado Road

4b. City, Town, or Location of Death

Federalsburg

4c. County of Death

Dorchester

Funeral
Director

5. Social Security Number

213-12-5336A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr. 22, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Federalsburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6761 Eldorado Road

10f. Zip Code

21632

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Boston

18. Mother's Name (First, Middle, Maiden Surname)

Laura Boston

19a. Informant's Name/Relationship (Type, Print)

Mary English/Sister-in-law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6761 Eldorado Road, Federalsburg, MD 21632

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mardela Springs Cem. 11/14

Date

20c. Location - City or Town, State

Mardela Springs, MD

21. Signature of Funeral Service Licensee

Mahmud A. Eshon

22. Name and Address of Facility

Frampton-Hawkins-Eskow Funeral Home, PA
PO Box 43, Federalsburg, MD 2163223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Cardio respiratory Arrest

Due to (or as a consequence of):

b. Dehydration

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aneurysm

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mahmud A. Eshon MD

29c. License number

C10004910

29d. Date signed (Month, Day, Year)

11/11/99

30. Name and address of person who completed cause of death (Item 23e), (Type, Print)

401 Concord Road, Blades, DE 19973. MANESH PATEL

State
Registrar

31. Date filed (Month, Day, Year)

11/11/99

32. Registrar's Signature

NOV 12 1999

Manish S. Patel

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36329

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | |
|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Roland Ellsworth Marshall, Jr. | | 2. Date of Death Month: NOVEMBER 10, 1999 Day: Year: | | 3. Time of Death 1842 PM |
| 4a. Facility Name (If not institution, give street and number) ROUTE 313 1/4 MILE NORTH OF ROUTE 318 | | 4b. City, Town, or Location of Death FEDERALSBURG | | 4c. County of Death CAROLINE |
| 5. Social Security Number 216-54-7761 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 48 Yrs. | 8. Date of Birth (Month, Day, Year) Dec. 14, 1950 | 9. Birthplace (State or Foreign Country) Maryland |
| Usual Residence of Decedent | | | | |
| 10a. State MD | 10b. County Dorchester | 10c. City, Town or Location Federalsburg | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 10e. Street and Number 6808 Eldorado Road | | 10f. Zip Code 21632 | | 10g. Citizen of What Country? United States |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 70-74 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (14 or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter | | 16b. Kind of Business/Industry Construction | | |
| 17. Father's Name (First, Middle, Last) Roland E. Marshall, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname) Nancy Harris Newnam | | |
| 19a. Informant's Name/Relationship (Type, Print) Darlene M. Marshall/wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6808 Eldorado RD, Federalsburg, MD 21632 | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Eastern Shore Vet. | | 20c. Location - City or Town, State 11/15 Hurlock, Maryland |
| 21. Signature of Funeral Service Licensee Michael F. Eskow | | 22. Name and Address of Facility Frampton-Hawkins- Eskow Funeral Home 216 N. Main St. Federalsburg, MD 21632 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Smoke inhalation and thermal injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 11-10-99 | | 28b. Time of Injury 1838 M |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred automobile accident | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Route 313 Caroline County, Maryland | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| 29b. Signature and title of certifier Stephen S. Radentz | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) NOVEMBER 12, 1999 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 PENN STREET BALTIMORE, MARYLAND 21201 | | | | |
| 31. Date filed (Month, Day, Year) NOV 15 1999 | | 32. Registrar's Signature B. Sparks | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36330

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Ann Mathias

2. Date of Death
Month Day Year

October 28, 1999

3. Time of Death

0518

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

212281078

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept 26, 1930

9. Birthplace (State or Foreign Country)

Va.

Usual Residence of Decedent

10a. State

Md.

10b. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7195 Statum Road

10f. Zip Code

21629

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
white/
American Indian15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Family

17. Father's Name (First, Middle, Last)

Paul

Quisenberry

18. Mother's Name (First, Middle, Maiden Surname)

Julia

Smith

19a. Informant's Name/Relationship (Type, Print)

James E. Mathias, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7195 Statum Road, Denton, Maryland 21629

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Capital Crematory

Date

10/31

20c. Location - City or Town, State

Dover, Delaware

21. Signature of Funeral Service Licensee

Rudolph P. Moore

22. Name and Address of Facility

Moore Funeral Home, P.A. 21629
12 South Second St., Denton, Maryland23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lung Cancer
Congestive heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James Sides MD

29c. License number

D 31376

29d. Date signed (Month, Day, Year)

10-29-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Sides 920 Market St Denton MD 21629

State
Registrar

31. Date filed (Month, Day, Year)

NOV - 1 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36331

| | | | | | | | | |
|--|---|--|--|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Russell Clifton Melton Jr | | | | 2. Date of Death Month Day Year Nov 12 1999 | | 3. Time of Death 4:30 AM | |
| | 4a. Facility Name (If not institution, give street and number) Corsica Hills Nursing Center | | | | 4b. City, Town, or Location of Death Centreville | | 4c. County of Death Queen Annes | |
| Funeral Director | 5. Social Security Number 226-24-5998 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 | | 8. Date of Birth (Month, Day, Year) July 15, 1927 | |
| | 9. Birthplace (State or Foreign Country) South Carolina | | 10a. State Maryland | | 10b. County Caroline | | 10c. City, Town or Location Greensboro | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 315 Sunset Avenue | | 10f. Zip Code 21639 | | 10g. Citizen of What Country? USA | | |
| 11. Mental Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1950 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bus Driver | | 16b. Kind of Business/Industry transportation | | | | |
| 17. Father's Name (First, Middle, Last) Russell Clifton Melton Sr | | | | 18. Mother's Name (First, Middle, Maiden Surname) Bessie L Porter | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Marie Melton spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 423 Greensboro, Maryland 21639 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greensboro Cemetery | | 20c. Location - City or Town, State Nov 15, 1999 Greensboro, Maryland | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Fleegle & Helfenbein Funeral Home PO Box 160 Greensboro, Maryland 21639 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Gangrene of foot Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last COPD | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | Approximate Interval Between Onset and Death 1m | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier  | | 29c. License number D32036 | | |
| 29d. Date signed (Month, Day, Year) 11/12/99 | | 29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gan J. Sprague 2108 O. Dash Drive Chester MD 21619 | | 29f. Date filed (Month, Day, Year) NOV 15 1999 | | 29g. Registrar's Signature  | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36332

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Anna Louise Mace | | | | 2. Date of Death Month Day Year November 9 1999 | | | | 3. Time of Death 7:30 PM | |
| | 4a. Facility Name (If not institution, give street and number) Caroline Nursing Home | | | | 4b. City, Town, or Location of Death Denton | | | | 4c. County of Death Caroline | |
| Funeral Director | 5. Social Security Number 212-16-1719 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) July 30, 1918 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Caroline | | 10c. City, Town or Location Greensboro | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 102 Hobbs Street | | | | 10f. Zip Code 21639 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) supervisor | | | 16b. Kind of Business/Industry Manufacturing | | |
| | 17. Father's Name (First, Middle, Last) George Langrell | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sophia Baynard | | | | | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 19a. Informant's Name/Relationship (Type, Print) John Mace Jr Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27499 Liden School Rd Federalburg, Maryland 21632 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greensboro Cemetery | | Date 11-13-99 | | 20c. Location - City or Town, State Greensboro, Maryland | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Fleegle & Helfenbein Funeral Home PO Box 160 Greensboro, Maryland 21639 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Breast Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death Months | | | | | | | | | |
| | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accidental 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier | | 29c. License number D31376 | | 29d. Date signed (Month, Day, Year) 11-10-99 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Sikes 920 Market St Denton MD 21627 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 15 1999 | | | | 32. Registrar's Signature | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transfer permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36333

| | | | | | | | | |
|--|--|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Arnold Leroy Olsen</u> | | | | 2. Date of Death Month <u>October</u> Day <u>31</u> Year <u>1999</u> | | 3. Time of Death <u>2:26 PM</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>Sinai Hospital, Baltimore</u> | | | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | 4c. County of Death ----- | |
| Funeral Director | 5. Social Security Number <u>07-2-24-1200</u> | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>68</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>July 23, 1931</u> | |
| | 9. Birthplace (State or Foreign Country) <u>New York</u> | | 10a. State <u>Maryland</u> | | 10b. County <u>Harford</u> | | 10c. City, Town or Location <u>Bel Air</u> | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number <u>1405 Beetree Ct.</u> | | 10f. Zip Code <u>21014</u> | | 10g. Citizen of What Country? <u>USA</u> | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>White</u> | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 5+) <u>2</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Engineer</u> | | 16b. Kind of Business/Industry <u>Telecommunications</u> | | | | |
| 17. Father's Name (First, Middle, Last) <u>Harry (nmn) Olsen</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Berdine (nmn) Johnson</u> | | | | |
| 19e. Informant's Name/Relationship (Type, Print) <u>Mary Olsen / Wife</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1405 Beetree Ct., Bel Air, MD 21014</u> | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Baker's Cemetery</u> | | 20c. Location - City or Town, State <u>11-3-99 Aberdeen, Maryland</u> | | 21. Signature of Funeral Service Licensee <u>Holly K. McCormas</u> | | |
| 22. Name and Address of Facility <u>McCormas Funeral Home, P.A.</u> | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <u>pancreatic adenocarcinoma</u> Due to (or as a consequence of): b. <u>liver failure</u> Due to (or as a consequence of): c. <u>upper gastrointestinal bleed</u> Due to (or as a consequence of): d. _____ | | Approximate Interval Between Onset and Death | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) ____ | | 28b. Time of Injury ____ M | | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred ____ | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ____ | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) ____ | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <u>Andrea Herzka, MD</u> | | 29c. License number <u>RES 0000</u> | | 29d. Date signed (Month, Day, Year) <u>October 31, 1999</u> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Andrea Herzka MD, Sinai Hospital of Baltimore, department of general surgery</u> | | 31. Data filed (Month, Day, Year) <u>NOV 03 1999</u> | | 32. Registrar's Signature <u>B. Spaw</u> | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36334

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James Roosevelt Proctor | | | | 2. Date of Death Month Day Year November 6, 1999 | | 3. Time of Death 2:30 p.m. | |
| | 4a. Facility Name (If not institution, give street and number) 2450 Davis Rd., Waldorf, MD | | | | 4b. City, Town, or Location of Death Waldorf, | | 4c. County of Death Charles | |
| Funeral Director | 5. Social Security Number 212-62-0248 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 45 Yrs. | | 8. Date of Birth (Month, Day, Year) DEC. 12-22-53 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Charles | | 10c. City, Town or Location Waldorf | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 2450 Davis Rd | | 10f. Zip Code 20603 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic | | 16b. Kind of Business/Industry Self-Employed | | | |
| | 17. Father's Name (First, Middle, Last) John R. Proctor | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary G. Proctor | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Phyllis Proctor - sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2450 Davis Road, Waldorf, MD 20603 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ST. Joseph Cath. Cem. | | 20c. Location - City or Town, State 11/10/99 Pomfret, Maryland | | | |
| | 21. Signature of Funeral Service Licensee  M00191 | | | | 22. Name and Address of Facility Adams Funeral Home Aquasco, Maryland 20608 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Bladder Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Physician /Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how Injury occurred | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| State Registrar | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier  | | 29c. License number D28352 | |
| | 29d. Date signed (Month, Day, Year) November 8, 1999 | | | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Krishan Mathur, MD, PO Box 1703, La Plata, MD 20646 | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 10 1999 | | | | 32. Registrar's Signature  | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDMENT #28F-WCHD 11/9/99 EPW

Certificate of Death

Reg. No.

99 36335

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN Howard PARSONS

2. Date of Death

November 4 1999

3. Time of Death

1118

Funeral
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

227-14-5581

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

03-31-22

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

VA

10b. County

Accomack

10c. City, Town or Location

Accomack

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

24441 Mary N. Smith Rd.

10f. Zip Code

23301

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 +

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

School System

17. Father's Name (First, Middle, Last)

Walter Parsons

18. Mother's Name (First, Middle, Maiden Surname)

KATE McIVER

19a. Informant's Name/Relationship (Type, Print)

Florence Parsons (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

24441 Mary N Smith Rd. Accomack, VA 23301

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Seymour Lot

Date

11/13/99

20c. Location - City or Town, State

Accomack, VA

21. Signature of Funeral Service Licensee

Samuel S. Savage

22. Name and Address of Facility

WHARTON FUNERAL HOME
22171 Wharton Rd. Accomack, VA 23301

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Multiple Trauma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hr

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☒ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

11/4/99

28b. Time of Injury

1000 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

MVA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Rt. 13 9010 Snashall Rd

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Pocomoke, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Chris Snyder D.O. DME

29c. License number

H50497

29d. Date signed (Month, Day, Year)

11/4/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher Snyder 106 MILDRED ST STE 201 SALISBURY, MD

31. Date filed (Month, Day, Year)

NOV 09 1999

32. Registrar's Signature

Barbara B. Sparks

State Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

227-14-5581

John Parsons

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36336

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Virgil Clifton Parker

2. Date of Death
Month Day Year
November 5, 19993. Time of Death
1935

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

578-42-0358

6. Sex

12 M 2 F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

June 6, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

5509 Whitehall Rd.

10f. Zip Code

21613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: 1954-5613. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Canning

17. Father's Name (First, Middle, Last)

Orlan Stewart Parker, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Anna Frischknecht

19a. Informant's Name/Relationship (Type, Print)

Norma D. Parker/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5509 Whitehall Rd., Cambridge, MD 21613

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Dorchester Mem. Pk.

Date

11-9

20c. Location - City or Town, State

Cambridge, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Curran-Bromwell Funeral Home, P.A.

308 High St., Cambridge, MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

5d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Urosepsis
Multiple decubiti
Cerebrovascular accident

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy
performed?

1 Yes 2 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2 No

25. Was case referred to medical
examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

26. Place of Death (Check only one)

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending
2 Accident investigation
3 Suicide 6 Could not be
4 Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35784

29d. Date signed (Month, Day, Year)

11/05/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrea Allen, M.D., 219 South Washington St., Easton, MD 21601

State
Registrar

31. Date filed (Month, Day, Year)

NOV 09 1999

32. Registrar's Signature

B. Sparks

Virgil Parker Ldb
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36337

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

ELIZABETH VIRGINIA

PETENBRINK

2. Date of Death

Nov. 4, 1999

3. Time of Death

1:40 p.m.

4a. Facility Name (If not institution, give street and number)

DEVLIN MANOR NURSING HOME

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

214-07-2617

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan 27, 1914

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegheny

10c. City, Town or Location

Cumberland

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

220 Somerville Avenue

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Albert M. Raupach

18. Mother's Name (First, Middle, Maiden Surname)

Leah V. (Leydig)

19a. Informant's Name/Relationship (Type, Print)

Robert F. Willingham -- son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

507 Lakeview Court; Stafford, VA 22554

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Lebanon Cemetery

Data

11/08

20c. Location - City or Town, State

Glenco, PA

21. Signature of Funeral Service Licensee

Michael J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home, P.A.
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Acute cell cancer*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

14 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Dis

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Anthony Bollino, Jr.

29c. License number

D17565

29d. Date signed (Month, Day, Year)

Nov. 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Anthony Bollino, Jr.; 922 National Highway; LaVale, MD 21502

State
Registrar

31. Date filed (Month, Day, Year)

NOV 05 1999

32. Registrar's Signature

Benjamin B. Sparks

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36338

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Paul Nelson Pippin

2. Date of Death

November 7, 1999 12:40PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

1127 Market Street

4b. City, Town, or Location of Death

Denton

4c. County of Death

Caroline

5. Social Security Number

215-26-5446

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 15, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland10b. County
Caroline10c. City, Town or Location
Denton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1127 Market Street

10f. Zip Code

21629

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
Caucasian15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
11 HS Grad.

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Self-employed

16b. Kind of Business/Industry

Carpenter

17. Father's Name (First, Middle, Last)

Luther James Pippin

18. Mother's Name (First, Middle, Maiden Surname)

Rosa Janet Coleman

19a. Informant's Name/Relationship (Type, Print)

Margaret Ruth Pippin Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1127 Market Street, Denton, Maryland 21629

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Denton Cemetery

Date

11/10

20c. Location - City or Town, State

Denton, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Moore Funeral Home, P.A.

12 South Second Street, Denton, Maryland 21629

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. *Altherosclerotic Heart disease*

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

year.

b. *Diabetic urethritis*

Due to (or as a consequence of):

years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastc. *End stage renal disease dialysis dependent*

Due to (or as a consequence of):

d. *Coronary vascular disease with RT Hemiparesis*

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury et
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier



29c. License number

D0046020

29d. Date signed (Month, Day, Year)

11/8/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S.I. ALI 506 Idlewild Avenue Easton MD 21601

31. Date filed (Month, Day, Year)

NOV - 8 1999

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36339

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|---|--|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GLADYS VIOLA PARDOE | | | 2. Date of Death Month NOVEMBER Day 7 , Year 1999 | | 3. Time of Death 1830 | | | |
| | 4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital | | | 4b. City, Town, or Location of Death Prince Frederick | | 4c. County of Death Calvert | | | |
| Funeral Director | 5. Social Security Number 263 12 1465 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 9 1921 | | |
| | 9. Birthplace (State or Foreign) Florida | | 10a. State Maryland | | 10b. County Calvert | | 10c. City, Town or Location Lusby | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 9766 H.G. Trueman Rd. | | 10f. Zip Code 20657 | | 10g. Citizen of What Country? United States | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) owner/prorietor | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) owner/prorietor | | 16b. Kind of Business/Industry grocery store | | | | |
| | 17. Father's Name (First, Middle, Last) Granville Green | | | 18. Mother's Name (First, Middle, Maiden Surname) Eva Matteson | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Geraldine Melvin- daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Middleham Chapel - Nov 10 1999 | | 20c. Location - City or Town, State Lusby, Maryland | | | | |
| | 21. Signature of Funeral Service Licensee B. Rauch | | | 22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. PNEUMONIA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death 1 week 1 week | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA, COPD, RENAL FAILURE | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier [Signature] | | 29c. License number D 36969 | | 29d. Date signed (Month, Day, Year) 10/8/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Scaria Mathew. M.D. Prince Frederick, Maryland 20678 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 10 1999 | | | 32. Registrar's Signature [Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36340

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--|---|--|--------------------------|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Rosalie Anna Marie Roberts | | | | 2. Date of Death Month Day Year Nov 1 1999 | | 3. Time of Death 12:15am | |
| | 4a. Facility Name (If not institution, give street and number) Westminster Nursing & Convalescent Ctr Westminster | | | | 4b. City, Town, or Location of Death Carroll | | 4c. County of Death Carroll | |
| Funeral Director | 5. Social Security Number 215-22-5930 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 97 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan 30 1902 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County Carroll | | 10c. City, Town or Location Westminster | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 1234 Washington Road | | 10f. Zip Code 21157 | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Own Home | | | |
| | 17. Father's Name (First, Middle, Last) John Hagedorn | | | | 18. Mother's Name (First, Middle, Maiden Surname) A. Thompson | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Craig Giles/Grandson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1121 Singer Drive Westminster, MD 21157 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery 11/3/99 Baltimore, MD | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASCVD Due to (or as a consequence of): b. pneumonia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 10 yrs 10 days | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier | | | | |
| 29c. License number D 25443 | | | | 29d. Date signed (Month, Day, Year) 11/1/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Mueller MD 688 Poole Road, Westminster MD 21157 | | | | 31. Date filed (Month, Day, Year) NOV 02 1999 | | | | |
| 32. Registrar's Signature | | | | 33. State Registrar | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

SEITE 20 VON 21

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36341

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Valedia Reed

2. Date of Death
Month Day Year
November 3 19993. Time of Death
9:45 Am

4a. Facility Name (If not institution, give street and number)

Fairhaven Health Center

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

094-09-4286

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb 2 1910

9. Birthplace (State or Foreign Country)

Pa.

Usual Residence of Decedent

10a. State
Md10b. County
Carroll10c. City, Town or Location
Sykesville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7200 Third Avenue

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+8

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

teacher

16b. Kind of Business/Industry

education

17. Father's Name (First, Middle, Last)

John C. Reed

18. Mother's Name (First, Middle, Maiden Surname)

Lizzie Kershner

19a. Informant's Name/Relationship (Type, Print)

Alice Reed Whittle (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3922 Classen Blvd. Oklahoma City, OK 73118

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

All County Cremation

Date

11-4-99

20c. Location - City or Town, State

Sykesville, Md

21. Signature of Funeral Service Licensee

▶ Paige Haight Herbert

22. Name and Address of Facility

Haight Funeral Home & Chapel

P.O. Box 195 Sykesville, Md 21784

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Cerebrovascular accident

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 weeks

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

▶ Ellis Mez MD

29c. License number

D22220

29d. Date signed (Month, Day, Year)

November 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ellis Mez MD 1645 Liberty Rd. Eldersburg, MD. 21784

31. Date filed (Month, Day, Year)

NOV 03 1999

32. Registrar's Signature

▶ Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36342

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ARCHIE W. RANTZ SR.

2. Date of Death

Month

Day

Year

November 5, 1999

3. Time of Death

1828

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

230-42-7386

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

11 12 35

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Virginia

10b. County

Accomack

10c. City, Town or Location

Withams

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7413 Neil Parker Road

10f. Zip Code

23488

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Dresser / Wayne Pump
machinest/mechanic

16b. Kind of Business/Industry

Industrial

17. Father's Name (First, Middle, Last)

Jesse W. Rantz

18. Mother's Name (First, Middle, Maiden Surname)

Violet Burton

19a. Informant's Name/Relationship (Type, Print)

Myra J. Rantz, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7413 Neil Parker Rd--Withams VA 23488

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Island Crematorium

Date

11-10-99

20c. Location - City or Town, State

Chincoteague VA

21. Signature of Funeral Service Licensee

James N. Lat

22. Name and Address of Facility

Fox Funeral Home
P O Box 278 Temperanceville VA 23442

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hepatic Encephalopathy

Due to (or as a consequence of):

b. Hepatic failure

Due to (or as a consequence of):

c. Fox Abuse

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

days

yr

yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph Rantetz, M.D.

29c. License number

20441

29d. Date signed (Month, Day, Year)

November 9, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Rantetz, M.D. 400 E Shore Dr. Salisbury, MD 21804

State
Registrar

31. Date filed (Month, Day, Year)

NOV 16 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Archie Rantz 7386 430 43 7386

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36343

Item #8 Film G777 11/22/99 kam/per FH Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LEONARD LEE RICE

2. Date of Death

Month Day Year
OCTOBER 30 1999

3. Time of Death

3:27 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

217-28-0078

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
FEB 9, 1927

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11808 EASTMAN ROAD N.E.

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: US ARMY13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

FORD MOTOR COMPANY

16b. Kind of Business/Industry

AUTO PRODUCTION

17. Father's Name (First, Middle, Last)

HOMER C. RICE

18. Mother's Name (First, Middle, Maiden Surname)

ZERNA JORDAN

19a. Informant's Name/Relationship (Type, Print)

VIRGINIA LEE RICE

WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11808 EASTMAN ROAD N.E. CUMBERLAND MARYLAND 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

ROCKY GAP VETS. CEMETERY NOV 3 1999 CUMBERLAND MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME P.A.

404 DECATUR STREET CUMBERLAND MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

10 DAYS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PERFORATED INTRA-ABDOMINAL VISCUS

MULTIPLE MYELOMA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D33280

29d. Date signed (Month, Day, Year)

Oct 31, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SUNIL GUPTA M.D., JOHNSON HEIGHTS MEDICAL BLDG., CUMBERLAND, MD 21502 SUITE 101

31. Date filed (Month, Day, Year)

NOV 02 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

LEONARD RICE 217-28-0078
Division of Vital Records, P.O. Box 68760,

Handwritten text, possibly a signature or date, located in the center-right area of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36344

| | | | | | |
|-------------------------------------|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Charles A. Robinette | | 2. Date of Death Month Day Year NOVEMBER 5, 1999 | | 3. Time of Death 12:30 PM |
| | 4e. Facility Name (If not institution, give street and number) Sacred Heart Hospital | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegany |
| Funeral Director | 5. Social Security Number 218-12-5545 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 74 Yrs. | If Under 1 Year Months Days If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Dec 5, 1924 |
| | 9. Birthplace (State or Foreign Country) MD | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State MD | 10b. County Allegany | 10c. City, Town or Location Cumberland | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 10e. Street and Number 12905 Winchester Road SW | | 10f. Zip Code 21502 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) electrical maint. | | 16b. Kind of Business/Industry Artmor Plastics | | |
| | 17. Father's Name (First, Middle, Last) George A. Robinette | | 18. Mother's Name (First, Middle, Maiden Surname) Ollie (Orndoff) | | |
| | 19e. Informant's Name/Relationship (Type, Print) Mary B. Robinette wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12905 Winchester Rd ;Cumberland MD 21502 | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sunset Memorial Park | | 20c. Location - City or Town, State 11/08 Cumberland, MD |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Scarpelli Funeral Home P.A. Cumberland, Maryland 21502 | | |
| Physician /Medical Examiner | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Dysrhythmia Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Cardio-pulmonary Arrest. Acute c. Left basal ganglia infarct. Anoxic d. encephalopathy | | | | Approximate Interval Between Onset and Death 40 hours |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cardio-pulmonary Arrest. Acute Left basal ganglia infarct. Anoxic encephalopathy | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 11/05/99 | | |
| | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 28f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28g. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier  | | 29c. License number D21244 | | 29d. Date signed (Month, Day, Year) NOVEMBER 6, 1999 |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JESUS TAN M.D. FROSTURG PLAZA FROSTBURG MD. 21532 | | | | |
| | 31. Date filed (Month, Day, Year) NOV 08 1999 | | 32. Registrar's Signature  | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36345

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph E. Robertson

2. Date of Death
Month Day Year
November 7, 19993. Time of Death
09:55 AM

4a. Facility Name (If not institution, give street and number)

Memorial Hospital & Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

217-10-7003

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Apr 24, 1914

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

207 Potomac Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

retired coning dept.

16b. Kind of Business/Industry

Textile

17. Fether's Name (First, Middle, Last)

George Robertson

18. Mother's Name (First, Middle, Maiden Surname)

Maude (Harding)

19a. Informant's Name/Relationship (Type, Print)

Florence I. Robertson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

207 Potomac Street; Cumberland MD 21502

20a. Manner of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sunset Memorial Park

Date

11/10 Cumberland, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home P.A.
Cumberland, Maryland 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia

Due to (or as a consequence of):

3 WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Adult respiratory distress syndrome

Due to (or as a consequence of):

3 WEEKS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Vik Poonai

29c. License number

D 36766

29d. Date signed (Month, Day, Year)

November 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vik Poonai, M.D., 920 National Highway, LaVale, MD 21502

31. Date filed (Month, Day, Year)

NOV 09 1999

32. Registrar's Signature

Vik Poonai

State
RegistrarBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Joseph Robertson
217-10-7003
Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Handwritten signature

NOV 6 1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36346**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

JAMES JOSEPH SMITH, SR.

2. Date of Death
Month Day Year
Nov. 08, 1999

3. Time of Death
3:04AM

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

5. Social Security Number

217-14-7006

6. Sex ☒ M ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 27, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Newburg

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

14825 Rock Point Road

10f. Zip Code

20664

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
 If Yes, Give Year or Dates: **1943-1946**

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: **White**

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Electric

17. Father's Name (First, Middle, Last)

Miriam Everett Smith

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Linton Smith

19a. Informant's Name/Relationship (Type, Print)

Doris Smith/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14825 Rock Point Rd. Newburg, MD 20664

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Trinity Memorial Gar. 11/11/99 Waldorf, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

David C. Echols

M00945

22. Name and Address of Facility

**AREHART-ECHOLS FUNERAL HOME, P.A.
 P.O. BOX 567 LA PLATA, MD 20646**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

RESPIRATORY FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?
☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George H. Wathen

29c. License number

D-20629

29d. Date signed (Month, Day, Year)

11/8/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George H. Wathen, MD 11345 Pembroke Square, Suite 103, Waldorf, Maryland 20603

State
Registrar

31. Date filed (Month, Day, Year)

NOV 10 1999

32. Registrar's Signature

Beverly B. Sparks

James J. Smith, Sr.
 Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36347

| | | | | | | | | |
|---|---|---|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ROBERT WILLIAM STERLING | | | | 2. Date of Death Month Day Year NOVEMBER 5 1999 | | 3. Time of Death 0415 | |
| | 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death WICOMICO | |
| Funeral Director | 5. Social Security Number 229-46-0355 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 63 Yrs. | 8. Date of Birth (Month, Day, Year) 04 06 1936 | 9. Birthplace (State or Foreign Country) VIRGINIA | | | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Virginia | 10b. County Accomack County | 10c. City, Town or Location 20025 Metompkin Rd., Parksley | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 20025 Metompkin Rd. | | | 10f. Zip Code 23421 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER/OPERATOR | | 16b. Kind of Business/Industry AGRICULTURE | | | |
| | 17. Father's Name (First, Middle, Last) Paul J. Sterling | | | | 18. Mother's Name (First, Middle, Maiden Summa) Doris Kelly | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) June Sterling - SPOUSE | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20025 Metompkin Rd., Parksley, Virginia 23421 | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory | | 20c. Location - City or Town, State Salisbury, Md. | | | |
| | 21. Signature of Funeral Service Licensee <i>John J. Williams</i> | | | 22. Name and Address of Facility WILLIAMS-PARKSLEY FUNERAL HOME 25046 PARKSLEY RD., PARKSLEY, VA. 23421 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): Irreversible shock Probably 2° to ischemic bowel b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Rheumatoid arthritis, diabetes mellitus | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number DZ6612 | | 29d. Date signed (Month, Day, Year) 11-5-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael E. Crouch MD, 105 Rte 1300 Rd, Suite 7, Salisbury, MD 21801 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 10 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36348**
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LEAH LANE STALEY | | | | 2. Date of Death Month NOV. Day 6, Year 1999 | | 3. Time of Death 4:55 am | |
| | 4a. Facility Name (If not institution, give street and number) 604-3 Water St. | | | | 4b. City, Town, or Location of Death Cambridge | | 4c. County of Death Dorchester | |
| Funeral Director | 5. Social Security Number 220-12-4877 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 82 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Mar. 31, 1917 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State Maryland | | 10b. County Dorchester | | 10c. City, Town or Location Cambridge | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 604-3 Water St. | | | | 10f. Zip Code 21613 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Business Manager and Partner | | | 16b. Kind of Business/Industry Industrial Belting | |
| 17. Father's Name (First, Middle, Last) Leroy Lane | | | | 18. Mother's Name (First, Middle, Maiden Surname) Leah Robinson | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Barbara S. Field/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604-3 Water St., Cambridge, MD 21613 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cambridge Crematory 11-8-99 | | Date | | 20c. Location - City or Town, State Cambridge, MD | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 | | | | |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) | | | | | | | | |
| e. Respiratory Failure Due to (or as a consequence of): | | | | | | | | 3 weeks |
| b. Acute exacerbation, chronic obstructive lung disease Due to (or as a consequence of): | | | | | | | | 1 month |
| c. Chronic obstructive pulmonary disease Due to (or as a consequence of): | | | | | | | | 10 years |
| d. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial fibrillation Lung Cancer | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier  | | 29c. License number D 11284 | | |
| | | | | 29d. Date signed (Month, Day, Year) Nov. 8, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A.R. Wilke, M.D., 400 Maryland Ave., Cambridge, MD 21613 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 09 1999 | | | | 32. Registrar's Signature  | | | | |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36349

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Mildred Young Stanley

2. Date of Death

November 03, 1999 1:29 P.M.

3. Time of Death

4a. Facility Name (If not institution, give street and number)

6634 Spring Mill Circle

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

220-01-7323

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Jan. 16, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5242 Airey Road

10f. Zip Code

21613

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

11

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Foster Grandparent

16b. Kind of Business/Industry

Community Support Agency

17. Father's Name (First, Middle, Last)

Enoch Young

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Banks

19a. Informant's Name/Relationship (Type, Print)

Arjorie Chandler

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6634 Spring Mill Circle Baltimore, MD. 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Pleasant Cemetery 11/08/99 Salem, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Janelle C. Henry

22. Name and Address of Facility

Henry Funeral Home, PA
510 Washington St. Cambridge, MD. 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

myasthenic Adenocarcinoma of

Approximate Interval Between Onset and Death

yes

Due to (or as a consequence of):

iron deficiency anemia

yes.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Daughters residence

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D50987

29d. Date signed (Month, Day, Year)

11/9/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmed Nawaz, 300 Aurora Street Cambridge, MD 21613

31. Date filed (Month, Day, Year)

NOV 09 1999

32. Registrar's Signature

[Signature]

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36350

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LARRY ARTHUR SMITH

2. Date of Death

Month Day Year
November 2, 1999

3. Time of Death

12:30 p.m.

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

217-56-8533

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 20, 1952

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

WV

10b. County

Mineral

10c. City, Town or Location

Keyser

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15 North Church Street

10f. Zip Code

26726

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Eyeglass/Optical
Manufacturing

17. Father's Name (First, Middle, Last)

Arthur S. Smith, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Frances L. Higgins

19a. Informant's Name/Relationship (Type, Print)

Arthur S. Smith, Sr./Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 North Church Street Keyser, WV 26726

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Queen's Point Cemetery

Date

Nov. 5

20c. Location - City or Town, State

Keyser, WV

21. Signature of Funeral Service Licensee

Brian L. Smith

22. Name and Address of Facility

Smith Funeral Home
85 S. Main Street Keyser, WV 2672623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Sepsis

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

72 hours

b. Advanced Large Cell Lymphoma

Due to (or as a consequence of):

Sept. 1999

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Dr. Zaman

29c. License number

D0023371

29d. Date signed (Month, Day, Year)

November 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Zaman, Johnson Heights, 625 Kent Avenue, Suite 102, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

NOV 08 1999

32. Registrar's Signature

Sparks

State
RegistrarBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Larry Smith 217-56-8533
Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36351

| | | | | | | | | | |
|---|--|--------------------------------|---|--|--|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Walter Martin Shaffer, Jr. | | | | | 2. Date of Death Month Nov. 3, Day 1999 Year | | 3. Time of Death 6:12 PM | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 217-36-1655 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 60 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) October 28, 1939 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State Maryland | | 10b. County Caroline | | 10c. City, Town or Location Denton | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 26012 Garey Road | | | | | 10f. Zip Code 21629 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Caucasian | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 HS Grad. College (1-4 or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/operator | | | 16b. Kind of Business/Industry Farm Equipment Business | |
| 17. Father's Name (First, Middle, Last) Walter Martin Shaffer, Sr. | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Emily Louetta Hayman | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary Jo Shaffer Wife | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26012 Garey Road, Denton, Maryland 21629 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Denton Cemetery | | Date 11/7/99 | | 20c. Location - City or Town, State Denton, Maryland | | |
| 21. Signature of Funeral Service Licensee  | | | | | 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Md. 21629 | | | | |
| 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>e. MYOCARDIAL INFARCTION</p> <p>Due to (or as a consequence of):</p> <p>b. HYPERLIPIDEMIA</p> <p>Due to (or as a consequence of):</p> <p>c. HYPERTENSION</p> <p>Due to (or as a consequence of):</p> <p>d.</p> </div> </div> | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | | 29c. License number D0053815 | | 29d. Date signed (Month, Day, Year) | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) KORAH M. PULLMOOD, MD 510 S. 5th AVE. DENTON, MD. 21629 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV - 5 1999 | | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

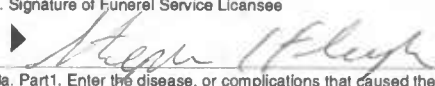
State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36352

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edward K Steele | | | | | | 2. Date of Death Month Day Year October 28 1999 | | 3. Time of Death 9:45 AM | |
| | 4a. Facility Name (If not institution, give street and number) Chestertown Nursing & Rehabilitation | | | | | | 4b. City, Town, or Location of Death Chestertown | | 4c. County of Death Kent | |
| Funeral Director | 5. Social Security Number 219-03-2795 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 94 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb 15, 1905 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State Maryland | | 10b. County Caroline | | 10c. City, Town or Location 26186 Goldsboro | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 26186 Goldsboro Rd | | | | 10f. Zip Code 21636 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 Collage (14 or 5+) | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) mechanic | | | 16b. Kind of Business/Industry Manufacturing | | |
| | 17. Father's Name (First, Middle, Last) Wilson K Steele | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary E Houser | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Elwyn Steele Son | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26186 Goldsboro Rd Goldsboro, Maryland 21636 | | | |
| | 20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greensboro Cemetery | | 20c. Location - City or Town, State Oct 30, 1999 Greensboro, Maryland | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Fleagle & Helfenbein Funeral Home PO Box 160 Greensboro, Maryland 21639 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardio Respiratory Arrest Severe Aortic Stenosis AND Severe Left Ventricular Dysfunction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Mitral Regurgitation, Multiple New CVA's, DM Type II Squamous Cell CA of Lip, Dementia, Left Foot Ischemia | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| 24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | | | | |
| 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier  29c. License number D50996 29d. Date signed (Month, Day, Year) 10/29/99 | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil Stoddard, 100 Brown St. Chestertown, Md. 21620 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV - 1 1999 32. Registrar's Signature  | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36353

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Margaret Smith

2. Date of Death

Month Day Year
October 28, 1999

3. Time of Death

2:00 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

11946 Greensboro Rd

4b. City, Town, or Location of Death

Greensboro

4c. County of Death

Caroline

5. Social Security Number

216-07-4533

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 15, 1915 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Greensboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11946 Greensboro Rd

10f. Zip Code

21639

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

seamstress

16b. Kind of Business/Industry

clothing

17. Father's Name (First, Middle, Last)

August Kibler

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Jones

19a. Informant's Name/Relationship (Type, Print)

Nancy Smith daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11946 Greensboro Rd Greensboro, Maryland 21639

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Denton Cemetery

Date

Nov. 1, 1999 Denton, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleagle & Helfenbein Funeral Home

PO Box 160 Greensboro, Maryland 21639

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. coronary Artery Disease

Due to (or as consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as consequence of):

c. Due to (or as consequence of):

d. Due to (or as consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aortic Stenosis
Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James Sides MD

29c. License number

D 31376

29d. Date signed (Month, Day, Year)

10-29-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

James Sides MD 920 Market Street Denton, Maryland 21629

31. Date filed (Month, Day, Year)

NOV - 1 1999

32. Registrar's Signature

Diana S. Apantel

State
RegistrarBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Medical Certification: To Be Completed by Physician/Medical Examiner

99 36354

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last) <i>MARY HELEN STEVENSON</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>October 30 1999</i> | | 3. TIME OF DEATH <i>12:20 AM</i> | |
| 4. SOCIAL SECURITY NUMBER <i>213-16-8731</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>87</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>JAN. 31 1912</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>MARYLAND</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>MANOKIN MANOR</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>PRINCESS ANNE</i> | |
| 9c. COUNTY OF DEATH <i>SOMERSET</i> | | | | 10a. STATE <i>MARYLAND</i> | | 10b. COUNTY <i>SOMERSET</i> | |
| 10c. CITY, TOWN OR LOCATION <i>PR. ANNE</i> | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER <i>11301 GREENWOOD School Rd</i> | |
| 10f. ZIP CODE <i>21835</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>AFRO AMERICAN</i> | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10 grade</i> College (1-4 or 5+) <i>None</i> | | | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Home Maker</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Self</i> | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Sidney M. Smith</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden, Surname) <i>ANGELINE Wilson</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>HELEN DUPRE Daughter</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>11301 GREENWOOD School Rd. PRINCE ANNE MD.</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>John Wesley Cem 11/4/99</i> | | 20c. LOCATION — City or Town, State <i>PR. ANNE MD.</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John A. Prince</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Salisbury Md. 917 West Idrilla St</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>End Stage Diabetic Renal Disease</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Insulin Dependent Diabetes Mellitus</i> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death <i>2 mos</i> <i>5 yrs</i> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Arteriosclerotic Cardiovascular Disease</i> <i>Essential Hypertension, Anemia</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gregorio M. Bellosa, M.D.</i> | |
| 29c. LICENSE NUMBER <i>D 29505</i> | | | | 29d. DATE SIGNED (Month, Day, Year) <i>10-30-99</i> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>GREGORIO M. BELLOSO, M.D. 5502 CHINABERRY DR., SALISBURY, MD 21801</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>NOV 04 1999</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Benita B. Sparks</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36355

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|--|---|--|---------------------------------|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Catherine</i> | | | 2. Date of Death Month <i>October</i> Day <i>31</i> Year <i>1999</i> | | | 3. Time of Death <i>4:05 AM</i> | | |
| | 4e. Facility Name (If not institution, give street and number) Harford Memorial Hospital | | | 4b. City, Town, or Location of Death Havre de Grace | | | 4c. County of Death Harford | | |
| Funeral Director | 5. Social Security Number 014-01-8592 | | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) 03/02/1915 | |
| | 9. Birthplace (State or Foreign Country) Massachusetts | | | 10a. State MD | | | 10b. County Harford | | |
| To Be Completed by Funeral Director | 10c. City, Town or Location Aberdeen | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 10e. Street and Number 3501 Garrett Court | | |
| | 10f. Zip Code 21001 | | | 10g. Citizen of What Country? USA | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | |
| | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 years | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | | 16b. Kind of Business/Industry Government | | |
| | 17. Father's Name (First, Middle, Last) Henry Joseph Hayes | | | 18. Mother's Name (First, Middle, Maiden Surname) Annie Keough | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Patricia Testerman- Daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3501 Garrett Court, Aberdeen, MD 21001 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harford Memorial Grdns. | | | 20c. Location - City or Town, State 11/3/99 Aberdeen, MD | | |
| | 21. Signature of Funeral Service Licensee <i>Swaine M. Smith</i> | | | 22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. ASPIRATION PNEUMONIA Due to (or as a consequence of): f. FALLOPIAN Cell CANCER Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): | | | Approximate Interval Between Onset and Death 2 Days 2 YR | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pleural Effusion B12 deficiency POLYNEUROPATHY secondary to cancer | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier <i>Matthew Wachsmann</i> | | | 29c. License number D40922 | | 29d. Date signed (Month, Day, Year) 11/2/99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MATTHEW WACHSMAN 407 S. Union Ave. Harford, MD 21078 | | | 31. Date filed (Month, Day, Year) NOV 03 1999 | | | | | | |
| 32. Registrar's Signature <i>B. Smith</i> | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

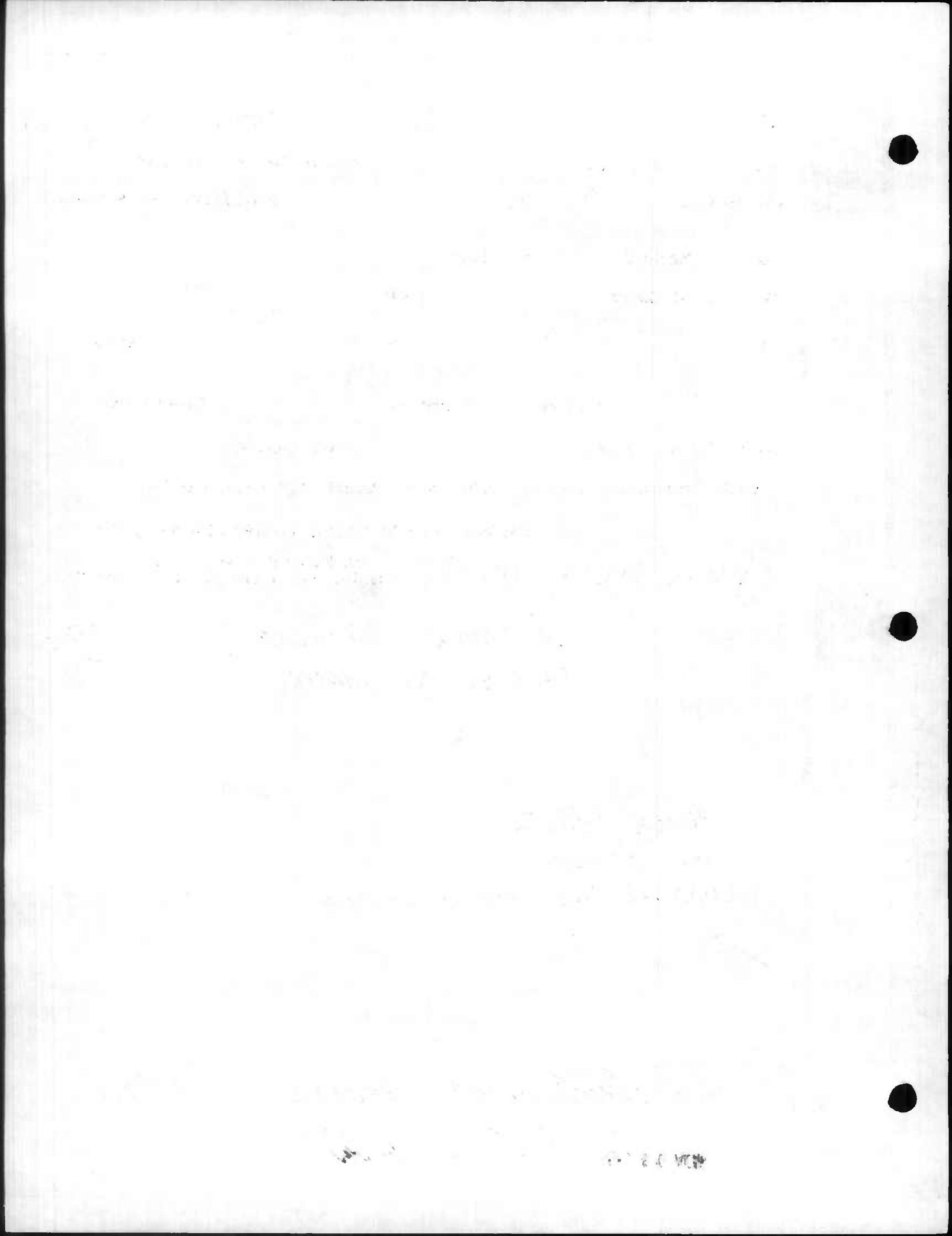
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36356

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|-----------------------|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Grace Julia Toomey | | | | 2. Date of Death Month Day Year November 8, 1999 | | 3. Time of Death 10:10 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number) Genesis Eldercare The pines | | | | 4b. City, Town, or Location of Death Easton | | 4c. County of Death Talbot | | |
| Funeral Director | 5. Social Security Number 222-01-7574 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 88 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Nov. 6, 1911 | | |
| | 9. Birthplace (State or Foreign Country) Delaware | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County Talbot | | 10c. City, Town or Location Easton | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number 610 Dutchman's Lane | | | | 10f. Zip Code 21601 | | 10g. Citizen of What Country? United States | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress | | | 16b. Kind of Business/Industry Sportswear | | |
| 17. Father's Name (First, Middle, Last) Fred Reynolds | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ella Morris Reynolds | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Clemmie V. Beauchamp/niece | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4529 Houston Branch Rd., Federalsburg, MD 21632 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Bloomery Cemetery | | 20c. Location - City or Town, State 11/12 Federalsburg, MD | | | | |
| 21. Signature of Funeral Service Licensee Michael F. Eskow | | | | | 22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home 216 N. Main St. Federalsburg, MD 21632 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Brain stem thrombosis Due to (or as a consequence of): b. Cerebral arteriosclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death 24 Hrs. Uncertain | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Rheumatoid arthritis | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | | 28d. Describe how injury occurred | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier Robert W. Trever, M.D. | | | 29c. License number D10938 | | 29d. Date signed (Month, Day, Year) Nov. 8, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Robert W. Trever, M.D. 7696 Ocean Gateway, Easton, MD 21601 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV - 9 1999 | | | 32. Registrar's Signature B. Sparks | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Mary Wooster

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36357
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary West Wooster

2. Date of Death

Month Day Year
11 07 1999

3. Time of Death

5:55 PM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Hartley Hall Nursing Home

4b. City, Town, or Location of Death

Pocomoke City

4c. County of Death

Worcester

5. Social Security Number

213-05-2013

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

3/25/1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Pocomoke City

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

9 Central Ave.

10f. Zip Code

21851

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: white15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Clothing

17. Father's Name (First, Middle, Last)

John Thomas West

18. Mother's Name (First, Middle, Maiden Surname)

Annie Conaway

19a. Informant's Name/Relationship (Type, Print)

John Wooster (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 Central Ave., Pocomoke City, MD 21851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

First Baptist Cemetery

Date

11/10/99

20c. Location - City or Town, State

Pocomoke City, MD

21. Signature of Funeral Service Licensee

Michael A. Dean MD1129

22. Name and Address of Facility

Holloway Melson Funeral Home, P.A.

103 Linden Ave., Pocomoke City, MD 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. CVA, Extensive Right Hemorrhagic Infarct 25 days
Due to (or as a consequence of):Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Essential Hypertension

Old CVA; Osteoarthritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Gregorio M. Belloso M.D.

29c. License number

D 29505

29d. Date signed (Month, Day, Year)

11-8-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GREGORIO M. BELLOSO, MD; 5302 CHINABERRY DR.; SALISBURY, MD 21801

State
Registrar

31. Date filed (Month, Day, Year)

NOV 09 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36358

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MILDRED MAE WILLIAMS

2. Date of Death

November 5, 1999

3. Time of Death

1510

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

214-34-7493

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10/22/22

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

WORCESTER

10c. City, Town or Location

POCOMOKE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

703 CEDAR STREET

10f. Zip Code

21851

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOUSECLEANING

16b. Kind of Business/Industry

DOMESTRIC

17. Father's Name (First, Middle, Last)

CHARLES MEARS

18. Mother's Name (First, Middle, Maiden Surname)

MAE DAVIS

19a. Informant's Name/Relationship (Type, Print)

GARY T GILLESPIE / (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21851
7570 POCOMOKE RIVER RD, POCOMOKE CITY, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETHANY METHODIST

Date

11/8/99

20c. Location - City or Town, State

POCOMOKE CITY, MD

21. Signature of Funeral Service Licensee

Michael A. Dean 11/11/99

22. Name and Address of Facility

HOLLOWAY NELSON FUNERAL HOME, PA
POCOMOKE CITY, MD 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Tuberculosis

Approximate Interval Between Onset and Death

2 months

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

Cancer Breast metastatic

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Paralysis 20-10 Bone mets. / cord involvement

Poor Nutritional status; Dementia, DVT

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael A. Dean

29c. License number

226612

29d. Date signed (Month, Day, Year)

11.5.99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Proulx MD, 103 Park Blvd Suite 7, Salisbury MD 21801

State
Registrar

31. Date filed (Month, Day, Year)

NOV 09 1999

32. Registrar's Signature

James B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Amended #4c, NLS,
11/9/99, Allegany County
Amended #31, NLS, 11/10/99, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36359

| | | | | | | | |
|---|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marshall Lee White | | | | 2. Date of Death Month Day Year November 3, 1999 | | 3. Time of Death 0055 |
| | 4a. Facility Name (If not institution, give street and number) Memorial Hospital | | | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegany |
| Funeral Director | 5. Social Security Number 220-52-7606 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 51 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Apr 12, 1948 | |
| | 9. Birthplace (State or Foreign Country) MD | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | |
| | 10a. State WV | 10b. County Mineral | 10c. City, Town or Location Wiley Ford | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number Route 1 Box 16 | | | 10f. Zip Code 26767 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Vietnam | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retired Camp Supervisor | | | 16b. Kind of Business/Industry Juvenile Justice | |
| 17. Father's Name (First, Middle, Last) Marshall White | | | | 18. Mother's Name (First, Middle, Maiden Surname) Gladys (Newman) | | | |
| 19a. Informant's Name/Relationship (Type, Print) Charlotte A. White wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 1 Box 16; Wiley Ford WV 26767 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Memorial Parll/06 Cumberland, MD | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Scarpelli Funeral Home P.A. Cumberland, Maryland 21502 | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Advanced Esophageal Carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death March 1996 |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D0023371 | | 29d. Date signed (Month, Day, Year) November 4, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Qamar U. Zaman Johnson Heights Medical Bldg. 625 Kent Ave. Suite 102 Cumberland | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV-09-1999 | | 32. Registrar's Signature  | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

MELODY JANE WILLIAMS

AMEND#23A 27-28F PER M.E.O. G777 11-22-99 J.A.

Certificate of Death

Reg. No. 99 36360

| | | | | | | | | |
|--|---|---|---|--|--|--|---------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Melody Jane Williams | | | | 2. Date of Death Month Day Year NOV. 5, 1999 | | 3. Time of Death 8:15 AM | |
| | 4a. Facility Name (If not institution, give street and number) 13600 Williams Road | | | | 4b. City, Town, or Location of Death CUMBERLAND | | 4c. County of Death ALLEGANY | |
| Funeral Director | 5. Social Security Number 218-02-0521 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 17 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) April 29, 1982 | | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Allegany | | 10c. City, Town or Location Cumberland | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 13600 Williams Rd. SE | | | | 10f. Zip Code 21502 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 Collega (1-4 or 5+) 10 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None | | 16b. Kind of Business/Industry | | |
| 17. Father's Name (First, Middle, Last) Alan Williams | | | | 18. Mother's Name (First, Middle, Maiden Surname) Barbara Jean Walther | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Alan Williams Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13600 Williams Rd., SE, Cumberland, MD 21502 | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation | | 20c. Location - City or Town, State Hampstead, MD | | 20d. Date 11/10/99 | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Eline Funeral Home Reisterstown, MD 21136 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SMOKE INHALATION Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) NOVEMBER 5, 1999 | | 28b. Time of Injury 4:15 AM | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) RESIDENCE | | 28d. Describe how injury occurred VICTIM OF HOUSE FIRE | | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 13600 WILLIAMS RD. CUMBERLAND, MD. | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) NOV. 10, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature

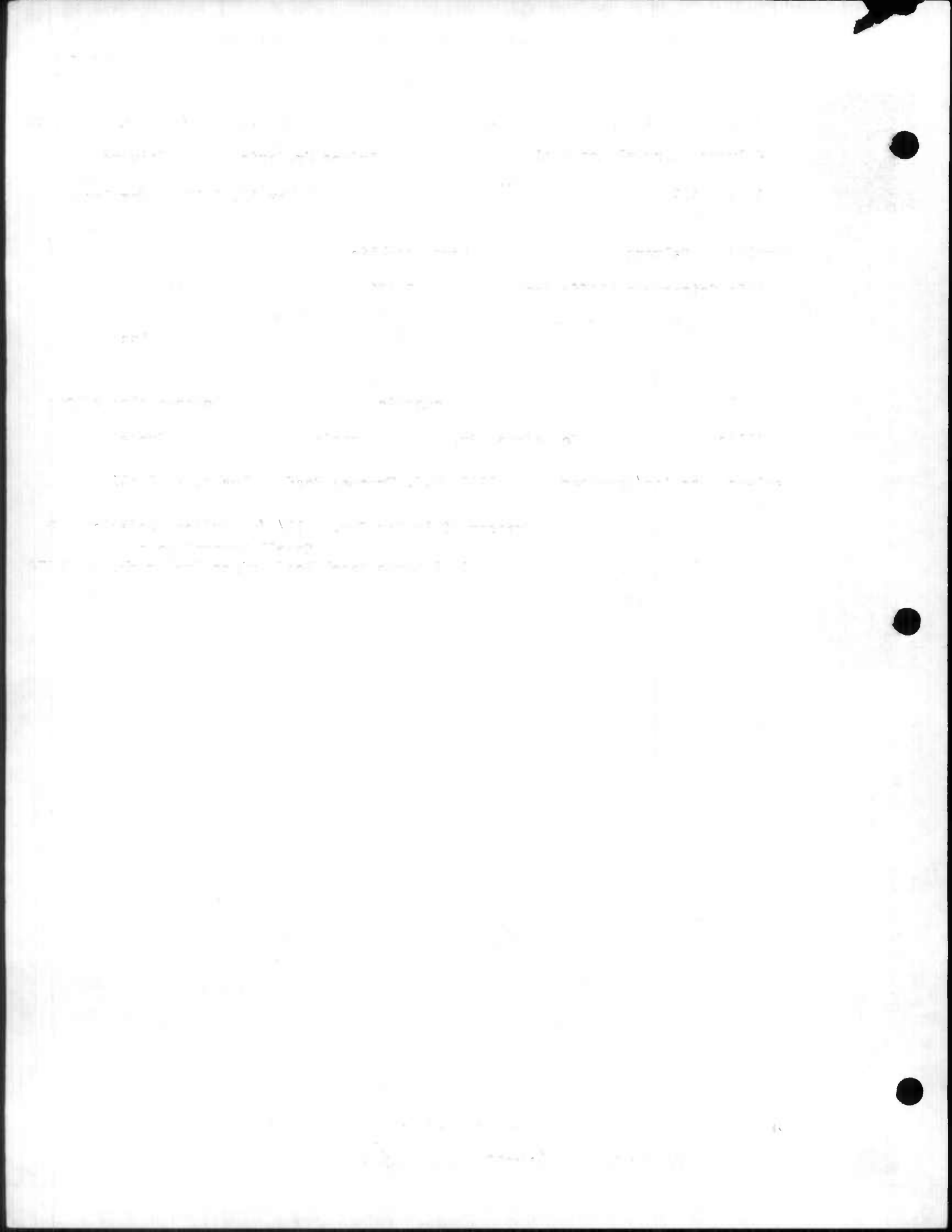
NOV 18 1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36361**
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HATTIE VIRGINIA WALLACE | | | | 2. Date of Death Month NOVEMBER Day 3 Year 1999 | | 3. Time of Death 0903am | | | |
| | 4e. Facility Name (If not institution, give street and number) Calvert Memorial Hospital | | | | 4b. City, Town, or Location of Death Prince Frederick | | 4c. County of Death Calvert | | | |
| Funeral Director | 5. Social Security Number 216-50-5457 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs, last birthday) 84 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 15, 1915 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State Maryland | 10b. County Calvert | 10c. City, Town or Location Port Republic | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number 1955 Scientists Cliffs Road | | | 10f. Zip Code 20676 | | 10g. Citizen of What Country? USA | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic | | | 16b. Kind of Business/Industry Someone else's home | | | | |
| | 17. Father's Name (First, Middle, Last) Willis Commodore, Sr. | | | 18. Mother's Name (First, Middle, Maiden Surname) Nettie Gross | | | | | | |
| Physician /Medical Examiner | 19e. Informant's Name/Relationship (Type, Print) Darlene Hutchins/Daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11470 H.G. Trueman Road Lusby, MD 20657 | | | | | | |
| | 20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greater Bible Way Chr. | | Date 11/8/99 | | 20c. Location - City or Town, State Prince Frederick, MD | | | |
| | 21. Signature of Funeral Service Licensee Blacks G. Sewell | | | 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cardio-Resp arrest Due to (or as a consequence of): b. CHF Due to (or as a consequence of): c. CAD Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28e. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Dale MD | | 29c. License number D50290 | | 29d. Date signed (Month, Day, Year) 11-4-99 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DHIREN H. SHAH, M.D., PRINCE FREDERICK, MD 20678 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) NOV 05 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | |



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State of Maryland / Department of Health and Mental Hygiene 99 36362
Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WILLIAM EDWARD WELCH | | | | 2. Date of Death Month Day Year November 3, 1999 | | 3. Time of Death 0755 am | |
| | 4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital | | | | 4b. City, Town, or Location of Death Prince Frederick | | 4c. County of Death Calvert | |
| Funeral Director | 5. Social Security Number 217 32 9847 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 90 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Feb 6, 1909 | 9. Birthplace (State or Foreign Country) Deale, Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Deale | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 620 Deale Road | | | | 10f. Zip Code 20751 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) waterman | | | 16b. Kind of Business/Industry fishing | |
| 17. Father's Name (First, Middle, Last) Thomas Franklin Welch | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ida Mae Deale | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Ida Mae Williams / niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 190, Deale, MD 20751 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | Data 11-4-99 | | 20c. Location - City or Town, State Alexandria, VA |
| 21. Signature of Funeral Service Licensee William B. Sparks | | | | 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End stage Heart failure Due to (or as a consequence of): b. diabetic ulcers with MRSA Due to (or as a consequence of): c. Diabetes, CAD Due to (or as a consequence of): d. ASCVD Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Dr. Kioumarce Yazdani | | 29c. License number D17168 | | 29d. Date signed (Month, Day, Year) 11/3/99 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kioumarce Yazdani, M.D. Prince Frederick, MD 20678 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 04 1999 | | | | 32. Registrar's Signature Sparks | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

8

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State of Maryland / Department of Health and Mental Hygiene

99 36363

Certificate of Death

Reg. No.

Amend 10acef 11/3/99

| | | | | | |
|---|---|--|---|---|--------------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Kellah Morris Wiltsey | | 2. Date of Death Month October Day 31 Year 1999 | | 3. Time of Death 11:30pm |
| | 4a. Facility Name (If not institution, give street and number) William Hill Manor | | 4b. City, Town, or Location of Death Easton | | 4c. County of Death Talbot |
| Funeral Director | 5. Social Security Number 252-38-6484 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 77 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) Feb. 23, 1922 | | 9. Birthplace (State or Foreign Country) Georgia | | |
| Usual Residence of Decedent | | | | | |
| 10a. State DE | | 10b. County Sussex | | 10c. City, Town or Location St-Michaels Seaford | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number RR2 Box 392F P.O. Box 463 | | 10f. Zip Code 21663 19973 | |
| 10g. Citizen of What Country? America | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11Yrs. College (1-4or 5+) | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Librarian | | 16b. Kind of Business/Industry Education | | 17. Father's Name (First, Middle, Last) Earl Odel Tharpe | |
| 18. Mother's Name (First, Middle, Maiden Surname) Kellah Morris Tharpe | | 19a. Intorment's Name/Relationship (Type, Print) Peggy W. Morey | | 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 159 St Michaels, Maryland 21663 | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematorium or other place) Eastern Shore Crematorium | | 20c. Location - City or Town, State 11/1/99 Lewes, Delaware | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility Watson-Yates Funeral Home Front & King Sts. Seaford, Delaware 19973 | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ASHD with Chronic Congestive Failure | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Myocardial Infarction | | | | | |
| 23c. Part III. Enter the cause of death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cerebral Arteriosclerosis with Cerebral Infarction | | | | | |
| 23d. Part IV. Enter the cause of death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. COPD with Chronic Bronchitis | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. Signature and title of certifier William H Wood, Jr. MD | | 29c. License number TD08715 | | 29d. Date signed (Month, Day, Year) 11/1/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. Wood, Jr. M.D. 506 Idlewild Ave. Easton, Maryland 21601 | | | | | |
| 31. Date filed (Month, Day, Year) November 20 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

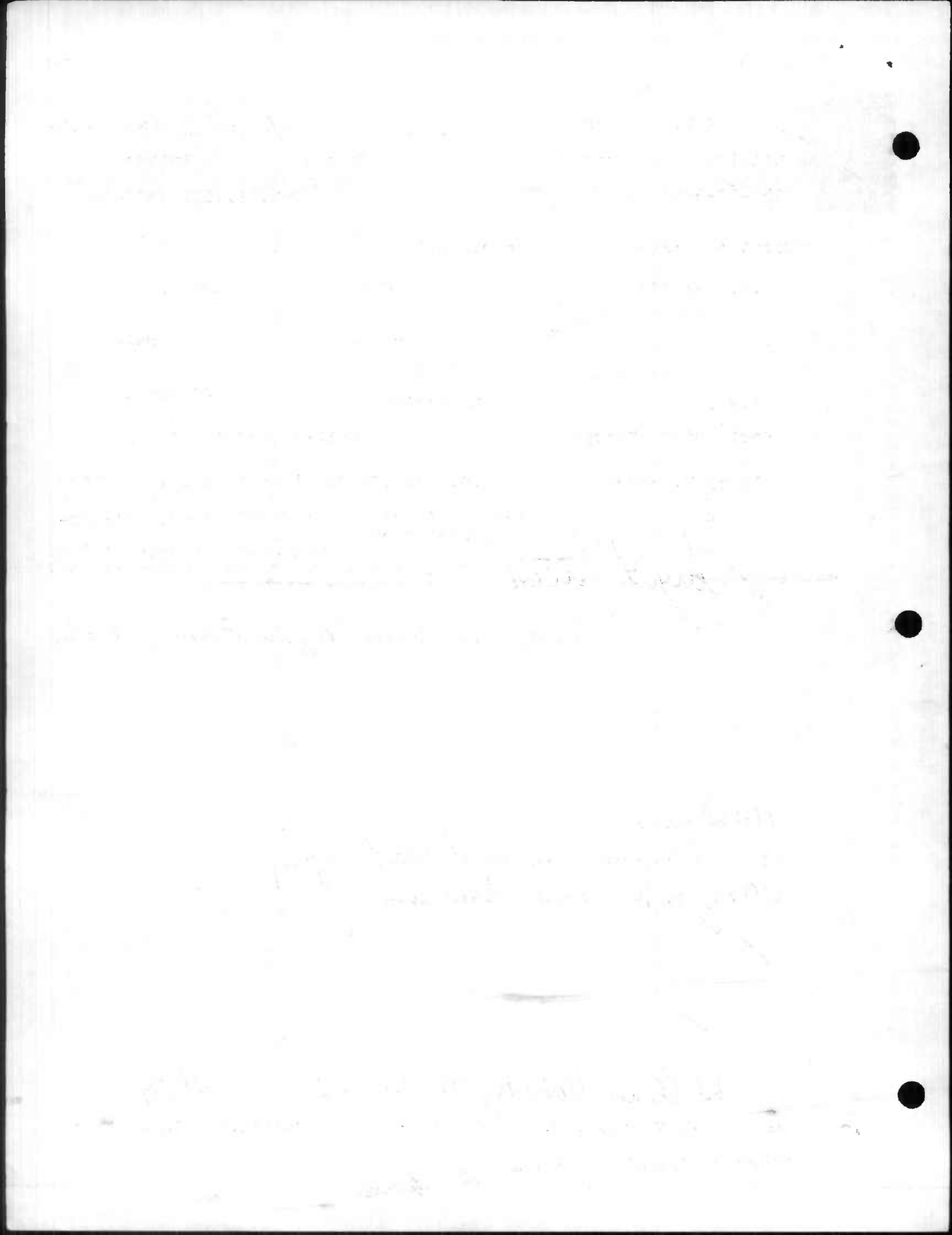
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36364**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Harriett Zepp

2. Date of Death

November 1 1999

3. Time of Death

2158

4a. Facility Name (If not institution, give street and number)

Carroll County General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

216-22-1885

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12-1-1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2720 Liberty Road

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Walter Edward Hobbs

18. Mother's Name (First, Middle, Maiden Surname)

Harriett Arrington

19a. Informant's Name/Relationship (Type, Print)

Mr. Gregory Zepp (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16313 Yeoho Road Sparks, MD 21152

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Mem. Park

Date

11/5/99

20c. Location - City or Town, State

Sykesville, MD

21. Signature of Funeral Service Licensee

Brian A. Haight

22. Name and Address of Facility

HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195)

Sykesville, MD 21784 (410)-795-1400

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 wk

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Endocarditis

Due to (or as a consequence of):

Several wks

c. Disseminated Intravascular Coagulation

Due to (or as a consequence of):

1 wk

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Mitral Valve Vegetation, Pancreatic Fistula

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Brian A. Haight

29c. License number

D37444

29d. Date signed (Month, Day, Year)

Nov. 3rd 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alexander Byrd, 245 Seiner Ave Suite #307, Westminster, MD, 21157

31. Date filed (Month, Day, Year)

NOV 03 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

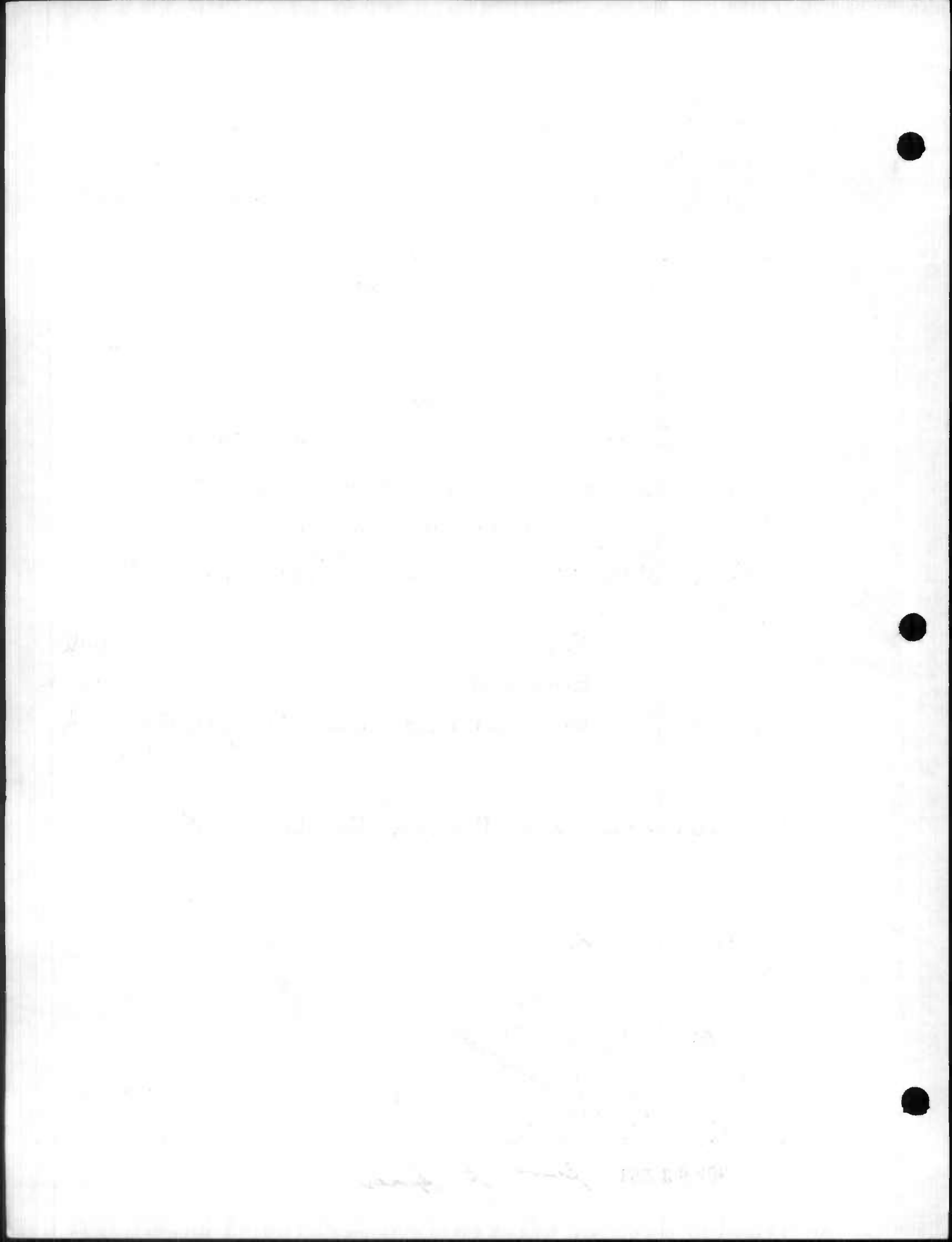
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND#31 PER D.V.R. G777 11-22-99 State of Maryland / Department of Health and Mental Hygiene

AMEND#27-28F PER M.E.O. G777 11-22-99 J.A.

Certificate of Death

Reg. No. 99 36365

| | | | | | | | | |
|---|--|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Gary Albritton | | | | 2. Date of Death Month Day Year October 30 1999 | | 3. Time of Death 0719 | |
| | 4a. Facility Name (If not institution, give street and number) University of Maryland Medical System | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 214-72-7792 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 41 Yrs. | | 8. Date of Birth (Month, Day, Year) September 21, 1958 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 2800 HILLSDALE Rd | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ROOFER | | 16b. Kind of Business/Industry BUILDING TRADES | | | |
| | 17. Father's Name (First, Middle, Last) ARTHUR LEE ALBRITTON | | | | 18. Mother's Name (First, Middle, Maiden Surname) SYLVIA HENDERSON | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) SYLVIA MCKNIGHT | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2800 HILLSDALE Rd, BALTO, MD 21215 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO INC | | 20c. Location - City or Town, State BALTIMORE | | 20d. Date 11-4-99 | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Russell W. Smith | | | | 22. Name and Address of Facility 4600 LIBERTY HWY, BALTO, MD HOWELL FUNERAL HOME | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cocaine & heroin overdose Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) OCT. 28, 1999 | | 28b. Time of Injury UNK. P M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred UNKNOWN | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) 700 BLK. FREMONT AVE. BALTO. MD. | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier Darlene Fidler MD | | | | 29c. License number 12428 | | 29d. Date signed (Month, Day, Year) October 30, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Darlene Fidler, MD 21 South Greene Street, Baltimore, MD 21201 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) October 30, 1999 | | | | 32. Registrar's Signature James B. Sparks | | | |
| | NOV 22 1999 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

4

Handwritten signature or initials

NOV 8 1988

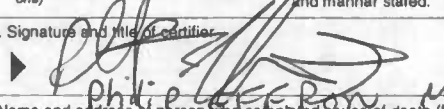
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amended Item #7 perFH 6777 11/22/99 EW

Reg. No. 99 36366

| | | | | | | | | | | |
|--|---|---------------------------|---|--|---|---------------------------------|--|--|---|--|
| Physician /Medical Examiner | 1. Decedant's Name (First, Middle, Last) Lee B. Askin | | | | 2. Date of Death Month Nov Day 11 Year 1999 | | | | 3. Time of Death 1337 | |
| | 4a. Facility Name (If not institution, give street and number) Santai ER 7 (ED) | | | | 4b. City, Town, or Location of Death Baltimore MD | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 218-05-5952 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) 02 02 22 | | 9. Birthplace (State or Foreign Country) PENNSYLVANIA | |
| | Usual Residence of Decedant | | | | | | | | | |
| 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 4000 N. CHARLES STREET APT. #1214 | | | | 10f. Zip Code 21218 | | | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedant of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS College (14 or 5+) CLAIMS SPECIALIST | | | | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | | | 16b. Kind of Business/Industry SOCIAL SECURITY | | |
| 17. Father's Name (First, Middle, Last) HARRY | | | | 18. Mother's Name (First, Middle, Maiden Summa) BOSK | | | | 19. Informant's Name/Relationship (Type, Print) MR. HARRY BOSK -NEPHEW | | |
| 19a. Informant's Name/Relationship (Type, Print) MR. HARRY BOSK -NEPHEW | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 CARRIAGE WALK COURT BALTO., MD 21234 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) B'NAI ISRAEL CONGREGATION-11/14/1999 BALTO., MD | | | | 20c. Location - City or Town, State | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility SOL LEVINSON BROS., INC.- 8900 REISTERSTOWN ROAD BALTO., MD 21208 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerosis Due to (or as a consequence of): b. Coronary artery disease Due to (or as a consequence of): c. ... Due to (or as a consequence of): d. ... Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 3915 5915 | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how Injury occurred | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and Title of certifier  Philip Askin MD | | | | 29c. License number 036709 | | | | 29d. Date signed (Month, Day, Year) November 12, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 V. Belvedere Ave Baltimore, Maryland 21215 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | | | 32. Registrar's Signature  | | | | | | |

34

7.15.1

Handwritten signature

NOV 2 1964

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36367

| | | | | | | | | | | |
|--|---|--|---|--|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ROBERT RICHARD AULHOUSE | | | | 2. Date of Death Month Day Year NOVEMBER 17 1999 | | | | 3. Time of Death 2:30 AM | |
| | 4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 204 26 9561 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 65 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 2, 1934 | | 9. Birthplace (State or Foreign Country) Pennsylvania | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Linthicum Heights | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 295 Regency Circle | | | | 10f. Zip Code 21090 | | | | 10g. Citizen of What Country? U.S. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrical Engineer | | 16b. Kind of Business/Industry Westinghouse | | | | | |
| | 17. Father's Name (First, Middle, Last) George Robert Aulhouse | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sarah Brown | | | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Phyllis Aulhouse / wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 295 Regency Circle Linthicum Heights, Md. 21090 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | Date 11/20/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee <i>Donna J. Zimowski</i> | | | | 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Esophageal cancer with metastasis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 17 days | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, hypercholesterolemia | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Sumabala Kasibhotla MD</i> | | | | 29c. License number P12090 | | 29d. Date signed (Month, Day, Year) NOVEMBER 17 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUMABALA KASIBHOTLA 3001 S. HANOVER ST BALTIMORE 21225 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 20 1999 | | 32. Registrar's Signature <i>Benita B. Sparks</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36368

Certificate of Death

Reg. No.

| | | | | | |
|--|---|--|--|--------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Norman Brown | | 2. Date of Death Month November Day 16 Year 1999 | | 3. Time of Death 11:00 PM |
| | 4a. Facility Name (If not institution, give street and number) 7841 Lockwood Road | | 4b. City, Town, or Location of Death Dundalk | | 4c. County of Death Baltimore |
| Funeral Director | 5. Social Security Number 212-32-2274 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 64 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) Jan. 18, 1935 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State Maryland | 10b. County Baltimore | 10c. City, Town or Location Dundalk | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 7841 Lockwood Road | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? United States |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1954-56 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4 or 5+) College | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Radio Maintenance Technician | | 16b. Kind of Business/Industry Baltimore City | | |
| | 17. Father's Name (First, Middle, Last) Arthur Pierce Brown, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname) Agnes Hersh | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mrs. Jane M. Brown (Wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7841 Lockwood Road Dundalk, Maryland 21222 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Ht. of Jesus Cem. | | 20c. Location - City or Town, State 11/22/99 Dundalk, Maryland |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASCVD - Coronary artery disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 3 yrs |
| | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Hypertrophic cardiomyopathy | | | | |
| Division of Vital Records, P.O. Box 68760, | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | |
| State Registrar | 29b. Signature and title of certifier | | 29c. License number D-12980 | | 29d. Date signed (Month, Day, Year) 11/17/99 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7801 Xxxxx Rd #101A Towson Md 21204 | | | | |
| AH | 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature | | |

ORIGINAL

NOV 2 1952

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36369

AMEND ITEM: #19A PER F.H. G778 12-3-99 WR.

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Monica Barker | | 2. Date of Death Month November Day 20 Year 1999 | | 3. Time of Death 11:05 A.M. | |
| 4a. Facility Name (If not institution, give street and number) Catonsville Commons | | 4b. City, Town, or Location of Death Catonsville | | 4c. County of Death Baltimore | |
| 5. Social Security Number 140-01-6197 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | |
| 8. Date of Birth (Month, Day, Year) July 8, 1909 | | 9. Birthplace (State or Foreign Country) New York | | | |
| Usual Residence of Decedent | | 10a. State Maryland | | 10b. County Howard | |
| 10c. City, Town or Location Ellicott City | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 4941 Webbed Foot Way | | 10f. Zip Code 21043 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | |
| 16b. Kind of Business/Industry Own Home | | 17. Father's Name (First, Middle, Last) John Cravit | | 18. Mother's Name (First, Middle, Maiden Surname) Virginia Brazong | |
| 19a. Informant's Name/Relationship (Type, Print) FRANK KOENIG / son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4941 Webbed Foot Way Ellicott City, MD. 21043 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | 20c. Location - City or Town, State Catonsville, Maryland | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Urinary Tract infection Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Peptic Ulcer Disease Dementia | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | Approximate Interval Between Onset and Death few days few days | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier Geetha Raja MD | | | |
| 29c. License number JD7541 | | 29d. Date signed (Month, Day, Year) Nov 20, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GEETHA RAJA, 4367 HOLLINS FERRY RD, BALTIMORE, MD-21227 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature | | | |

Handwritten text at the bottom of the page, possibly a signature or date, followed by the printed text "COPY 2-10-68".

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36370
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NOREEN BATTERSBY

2. Date of Death
Month Day YearNOVEMBER 18th 1999

3. Time of Death

7.25 AM

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

213-58-4031

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 24, 1950

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3810 Elmcroft Road

10f. Zip Code

21133

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (14 or 5+)

2+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

Darwin H. McCracken

18. Mother's Name (First, Middle, Maiden Surname)

Anna Pearl Presley

19a. Informant's Name/Relationship (Type, Print)

Wayne Battersby - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

350 1/2 Fair Avenue; Westminster, Maryland 21157

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore/Washington Crem. 11/22/99 Laurel, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.
8728 Liberty Road; Randallstown, Maryland 21133Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. SEPSIS

Due to (or as a consequence of):

b. SEVERE DIABETIC KETOACIDOSIS

Due to (or as a consequence of):

c. RENAL FAILURE

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

5 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] P Mehta M.D.

29c. License number

D0041410

29d. Date signed (Month, Day, Year)

November 18th, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD 21133

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature or initials

NOV 2 1952

99-6939-510

LERMON

BARNETT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36371

Funeral Director

Physician
/Medical
Examiner

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Lermon Eugene Barnett | | | | 2. Date of Death Month NOVEMBER Day 18 , Year 1999 | | 3. Time of Death 11:07P.M. | |
| 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| 5. Social Security Number 215-96-0045 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 22 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec 17, 1976 | |
| 9. Birthplace (State or Foreign Country) Maryland | | 10. Usual Residence of Decedent 10a. State MD 10b. County N/A 10c. City, Town or Location Baltimore 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | |
| 16b. Kind of Business/Industry Construction | | 17. Father's Name (First, Middle, Last) Lermon Eugene Barnett, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname) Robin Marie Williams | | 19a. Informant's Name/Relationship (Type, Print) Lermon Barnett Sr.-Father | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3307 Edmondson Avenue, Baltimore, MD 21229 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery | | 20c. Location - City or Town, State Baltimore,, MD | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple Gunshot Wounds | | Approximate Interval Between Onset and Death | |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 11/18/99 28b. Time of Injury 2219 M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred Subject shot | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3800 Blk Graceland Ave | | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. Signature and title of certifier  | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) NOVEMBER 19, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201 | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36372

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ALICE LOUISE BENTZ | | | | 2. Date of Death Month Day Year NOVEMBER 19, 1999 | | 3. Time of Death 9:25 AM | |
| | 4a. Facility Name (If not institution, give street and number) MARINER HEALTH OF GLEN BURNIE | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | 4c. County of Death ANNE ARUNDEL | |
| Funeral Director | 5. Social Security Number 229-24-9116 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) 7/25/1916 | |
| | 9. Birthplace (State or Foreign Country) Virginia | | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Glen Burnie | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 601 Mayo Road | | 10f. Zip Code 21061 | | 10g. Citizen of What Country? U. S. A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tecnician | | 16b. Kind of Business/Industry Westinghouse | | 17. Father's Name (First, Middle, Last) Robert Reynolds | |
| | 18. Mother's Name (First, Middle, Maiden Summa) Mazzie Leftwich | | 19a. Informant's Name/Relationship (Type, Print) Irvin James Bentz | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 Mayo Road Glen Burnie, MD 21061 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park | | 20c. Location - City or Town, State Glen Burnie, MD | | 21. Signature of Funeral Service Licensee <i>Michael C. J. [Signature]</i> | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W. GLEN BURNIE, MD. 21061 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple Strokes Due to (or as a consequence of): Hypertension Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 10 yrs + 10 yrs + | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number D14136 | | 29d. Date signed (Month, Day, Year) 11/20/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DALIT S. SAWHNEY Suite 201 Crain Towers Glen Burnie md 21061 | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | 33. Registrar's Signature <i>[Signature]</i> | | 34. Registrar's Signature <i>[Signature]</i> | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36373

| | | | | | | | | | | |
|---|---|--|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) PHOEBE R. BERMAN | | | | | | 2. Date of Death Month Day Year Nov. 20, 1999 | | 3. Time of Death 7 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) 1116 Greenspring Valley Road | | | | | | 4b. City, Town, or Location of Death Lutherville | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 213-01-3096 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 89 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 30, 1910 | | 9. Birthplace (State or Foreign Country) Callensburg, PA | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Md. | | 10b. County Baltimore | | 10c. City, Town or Location Lutherville | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 1116 Greenspring Valley Road | | | | 10f. Zip Code 21093 | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 Yrs College | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Horse Farm | | | 16b. Kind of Business/Industry Owner | | | |
| 17. Father's Name (First, Middle, Last) John Rhea | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Martha Schweitzer | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Peter B. Shreffley POA | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 Harmony Circle West Chester, Pa. 19380 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation Service | | 20c. Date 11/22/99 | | 20d. Location - City or Town, State Hampstead, Md. | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, Md. 21136 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinomatosis Due to (or as a consequence of): b. Breast cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number A 5268 | | 29d. Date signed (Month, Day, Year) November 20, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leonard C. Arman MD, 2805 Grady Wd Ln. Balt, Md. | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36374

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary L. Brafford

2. Date of Death
Month Day Year

November 16, 1999

3. Time of Death

12:00PM

4a. Facility Name (If not institution, give street and number)

26 Pendragon Circle

4b. City, Town, or Location of Death

Reisterstown

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

563-32-3855

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 29, 1929

9. Birthplace (State or Foreign Country)

CA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

26 Pendragon Circle

10f. Zip Code

21136

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (9-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

School Aid

16b. Kind of Business/Industry

Balt. Co. Dept. of Age.

17. Father's Name (First, Middle, Last)

Amos Brafford

18. Mother's Name (First, Middle, Maiden Summa)

Edith Gibson

19a. Informant's Name/Relationship (Type, Print)

Craig H. Schroeder

Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3822 Shiloh Ave., Hampstead, MD 21074

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Carroll Cremation

Date

11/20/99

20c. Location - City or Town, State

Hampstead, MD

21. Signature of Funeral Service Licensee

Eline

22. Name and Address of Facility

11824 Reisterstown Rd.
Eline Funeral Home Reisterstown, MD 21136

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

a. Cardiac Arrest due to Arrhythmia.

Due to (or as a consequence of):

b. HASCVD.

Due to (or as a consequence of):

c. HBP.

Due to (or as a consequence of):

d. VBI TIA.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

As Above

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

N/A.

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Patel MD.

29c. License number

D 28530

29d. Date signed (Month, Day, Year)

11/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dino S. Patel, M.D. Suite 202 Walker Center, 19 Walker Ave., Baltimore, MD 21208

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

D. Patel

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

3

State
Registrar

1997

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36375**
Certificate of Death

Amended Item29c per FR, 6777,11/22/99dhh

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **VIVIAN A. BURRELL** 2. Date of Death Month **11** Day **15** Year **99** 3. Time of Death **6 00 AM**

Funeral
Director

4a. Facility Name (If not institution, give street and number) **5118 THUNDER HILL RD** 4b. City, Town, or Location of Death **COLUMBIA** 4c. County of Death **HOWARD**

5. Social Security Number **217-16-5166** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **78** yrs. 8. Date of Birth (Month, Day, Year) **04-13-21** 9. Birthplace (State or Foreign Country) **MD**

Usual Residence of Decedent

10a. State **MD** 10b. County **HOWARD** 10c. City, Town or Location **COLUMBIA** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **5118 THUNDER HILL RD.** 10f. Zip Code **21045** 10g. Citizen of What Country? **USA**

11. Marital Status ☒ Never Married ☐ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **BLACK**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **12 TH GRADE** College (1-4or 5+) **N/A** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **CUSTODIAN** 16b. Kind of Business/Industry **BALTD. COUNTY SCHOOLS**

17. Father's Name (First, Middle, Last) **HENRY BURRELL** 18. Mother's Name (First, Middle, Maiden Surname) **ADELAIDE KANE**

19a. Informant's Name/Relationship (Type, Print) **LOBBRAINE DORSEY / SISTER** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **5118 THUNDER HILL RD. COLUMBIA, MD 21045**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **KING MEMORIAL PARK** Date **11-19-99** 20c. Location - City or Town, State **RANDALLSTOWN, MD**

21. Signature of Funeral Service Licensee **W. Vaughn C. Greene** 22. Name and Address of Facility **VAUGHN C. GREENE FUNERAL SERVICE 5151 BALD. NATL PIKE, BALD. MD. 21229**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Respiratory Failure** Due to (or as a consequence of): **Acute Hypoxemia** Due to (or as a consequence of): **Pneumonia** Due to (or as a consequence of): **Chronic Bronchitis, Emphysema**

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. **Myocardial Ischemia** **Cypripedium** **Leukostasis** 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☐ No ☒ Probably ☐ Unknown 24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify) 27. Manner of Death ☒ Natural ☐ Pending investigation ☐ Accident ☐ Suicide ☐ Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier **Dr. Vaughn C. Greene** 29c. License number **00018847** 29d. Date signed (Month, Day, Year) **11/15/99**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **Margaret S. Brown 301 St. Paul Place 21202**

31. Date filed (Month, Day, Year) **NOV 22 1999** 32. Registrar's Signature **[Signature]**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in the funeral director, page 2 should be detached for use as the burial-transit permit.

Handwritten signature

NOV 3 1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36376

| | | | | | | | | |
|---|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edward Clay, Jr. | | | | 2. Date of Death Month Day Year NOVEMBER 18, 1999 | | 3. Time of Death 0630 AM | |
| | 4a. Facility Name (If not institution, give street and number) 4621 HARFORD ROAD (REAR) | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death NA | |
| Funeral Director | 5. Social Security Number 217-56-5839 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 48 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 07-07-51 | | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 3110 Evergreen Avenue | | | | 10f. Zip Code 21214 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (14 or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance | | | 16b. Kind of Business/Industry C&P Telephone Co. | |
| 17. Father's Name (First, Middle, Last) Edward Clay | | | | 18. Mother's Name (First, Middle, Maiden Surname) Annie Terry | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Michelle Clay | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 731 E. Coldspring Lane Baltimore, MD. 21212 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery | | 20c. Date 11-22-99 | | 20d. Location - City or Town, State Baltimore, MD. |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SMOKE INHALATION AND THERMAL INJURIES Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 11-18-99 | | 28b. Time of Injury 0530 AM | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred SELF-IMMOLATION |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) PEP BOYS LOADING DOCK | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4621 HARFORD ROAD BALTIMORE CITY, MARYLAND | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) NOVEMBER 18, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature or initials.

NOV 2 1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36377

| | | | | | | | | | | |
|--|--|--|---|--|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Williams | | | | 2. Date of Death Month Day Year November 18, 1999 | | | | 3. Time of Death 1842 | |
| | 4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death NA | |
| Funeral Director | 5. Social Security Number 218-42-3304 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 54 Yrs. | | 8. Date of Birth (Month, Day, Year) 09-07-45 | | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 2620 East Federal Street | | | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade College (14 or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Animal Service Technician Johns Hopkins | | | | 16b. Kind of Business/Industry Hosp. | | |
| 17. Father's Name (First, Middle, Last) Delbert Capers | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rosa Hannah | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Timothy Capers | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6511 Parsons Avenue Baltimore, Maryland 21215 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Kings Mem. Pk. Cemetery | | | 20c. Location - City or Town, State 11-23-99 Randallstown, MD | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Sepsis Due to (or as a consequence of): b. Perforated Sigmoid Colon Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 10 days 3 weeks | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier MD | | | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) November 18, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Satitpunnayacha 600 North Wolfe Street, Baltimore, MD 21287-9106 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | | | 32. Registrar's Signature | | | | | | |

NOV 5 1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36378

| | | | | | | | | | | |
|--|---|---|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Emma Cyzyk | | | | | | 2. Date of Death Month Day Year November 18 1999 | | 3. Time of Death 5:40 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER | | | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 218-28-1638 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 87 Yrs. | | 8. Date of Birth (Month, Day, Year) June 17 1912 | | 9. Birthplace (State or Foreign Country) Michigan | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Essex | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 404 Gerries Ave | | | | | | 10f. Zip Code 21221 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | | | 16b. Kind of Business/Industry Own Home | | |
| 17. Father's Name (First, Middle, Last) Jacob Mekolon | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Brodowski | | | | |
| 19a. Informant's Name/Relationship (Type, Print) John Cyzyk /husband | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Gerries Ave Baltimore, MD 21221 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Christ Lutheran Cem. | | Date Nov 22 1999 | | 20c. Location - City or Town, State Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee Anthony C. Connelly | | | | | | 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Insufficiency Due to (or as a consequence of): b. Adult Respiratory Distress Syndrome Due to (or as a consequence of): c. Aspiration Pneumonia Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 10 DAYS | | | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY Disease, HypoThyroid is CORONARY ARTERY Bypass Graft Right hip open Reduction, INTERNAL Fixation Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) November 3 1999 | | 28b. Time of Injury 4:00 P M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Fell down STEPS | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Maria Hanna, MD | | 29c. License number D40819 | | 29d. Date signed (Month, Day, Year) November 18, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR MARCO ZAMORA 9000 FRANKLIN SQUARE DR. BALTIMORE, MARYLAND 21221 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | | | 32. Registrar's Signature James B. Spauls | | | | | | |

ORIGINAL

[Faint, illegible handwritten text]

NOV 2 1952

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36379

| | | | | | | | | |
|--|--|---|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOHN COTHORN | | | | 2. Date of Death Month Day Year October 10, 1999 | | 3. Time of Death 10:50 am | |
| | 4a. Facility Name (If not institution, give street and number) 3718 Parkfield Road | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 215-16-7341 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 89 Yrs. | | 8. Date of Birth (Month, Day, Year) May 12, 1910 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3718 Parkfield Rd | | 10f. Zip Code 21208 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Principal | | 16b. Kind of Business/Industry Education | | | | |
| 17. Father's Name (First, Middle, Last) Lee Andrew Davis | | | | 18. Mother's Name (First, Middle, Maiden Surname) Amanda C. Cothorn | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Shirley Cothorn/niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3718 Parkfield Rd Baltimore, MD 21208 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | 20c. Location - City or Town, State | | | | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Prostate Cancer | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24e. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier John N. Aucott MD | | | | | | |
| 29c. License number D0030414 | | 29d. Date signed (Month, Day, Year) 11/16/99 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOHN N. Aucott 10755 Falls Rd, Lutherville, MD 21093 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36380

| | | | | | | | |
|---|---|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Elbert Cassell Cordle | | | | 2. Date of Death Month Day Year November 18 1999 | | 3. Time of Death 9:15 AM |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 227-44-1070 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 63 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 19 1936 | 9. Birthplace (State or Foreign Country) Virginia |
| | Usual Residence of Decedent | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Pasadena | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 8361 Lock Wood Road | | | 10f. Zip Code 21122 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1953-1957 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver | | 16b. Kind of Business/Industry Tractor Trailer | | |
| 17. Father's Name (First, Middle, Last) Hugh T. Cordle | | | | 18. Mother's Name (First, Middle, Maiden Surname) Myrtle Cordle | | | |
| 19a. Informant's Name/Relationship (Type, Print) Beverly A. Cordle (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8361 Lock Wood Rd. Pasadena, MD. 21122 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery | | Date Nov. 22 1999 | | 20c. Location - City or Town, State Crownsville, MD. | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Rd. Pasadena, MD. 21122 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cerebral bleed Due to (or as a consequence of): b. Status post Gastrostomy tube placement Due to (or as a consequence of): c. Dementia Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 6 months 6 months 6 months | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | | |
| | | | | 29c. License number D40519 | | 29d. Date signed (Month, Day, Year) 11-18-99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIRZA M. NUSSAIREG, 7845 OAKWOOD PROFESSIONAL BUILDING, Suite 200, Glen Burnie | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV. 22 1999 | | | | 32. Registrar's Signature | | | |

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten text at the bottom of the page, possibly a signature or date, followed by the printed text "COPY 2 S. VOM".

99 36381

FOR STATE 11-20-99 J.A. STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 REGISTRAR AMEND#20a-c PER F.H.67777 CERTIFICATE OF DEATH REG. NO.

| | | | | | |
|--|---------------------------|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Reed Colchagoff | | 2. DATE OF DEATH MONTH DAY YEAR October 28 1999 | | 3. TIME OF DEATH M 5:20 pm | |
| 4. SOCIAL SECURITY NUMBER | 5. SEX XX M 2 F | 6. AGE (In yrs. last birthday) YRS. 3 56 | 7. DATE OF BIRTH (Month, Day, Year) 10-28-99 | | 8. BIRTHPLACE (State or Foreign Country) |
| 9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Maryland | | 10b. COUNTY Glen Burnie | | 10c. CITY, TOWN OR LOCATION Glen Burnie | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 303 D Mountain Ridge | | 10f. ZIP CODE 21061 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) None College (1-4 or 5+) None | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) None | | 16b. KIND OF BUSINESS/INDUSTRY None | | 17. FATHER'S NAME (First, Middle, Last) Buff R. Colchagoff | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Robin E. Burngardner | | 19a. INFORMANT'S NAME (Type/Print) MRS. NIKKI CHILBOAT (STAFF) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) G.B.M.C., 6701 N. CHARLES, TOWSON, MD. 21204 | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNT CREMATORY | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND 21202 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. H. Jenkins | | 22. NAME AND ADDRESS OF FACILITY H.W. JENKINS & SONS CO. 4905 YORK RD BALTO., MD. 21212 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Incompetent Cervix DUE TO (OR AS A CONSEQUENCE OF): b. Spontaneous Rupture of Membranes DUE TO (OR AS A CONSEQUENCE OF): c. 22 week gestation Immature Fetus DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 3 weeks same day same day | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 1 2 2 | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Robert E. Ottenritter M.D. | | 29c. LICENSE NUMBER D31272 | |
| 29d. DATE SIGNED (Month, Day, Year) 10/28/99 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GBMC 6701 N. Charles St. Towson Maryland 21204 Robert E. Ottenritter, M.D. | | 31. DATE FILED (Month, Day, Year) NOV 22 1999 | |
| 32. REGISTRAR'S SIGNATURE Beverly S. Sparks | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1000 8 8 VOM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36382

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNE Deimel

2. Date of Death
Month Day Year

11 18 99

3. Time of Death

8:58 A.M.

4a. Facility Name (If not institution, give street and number)

ST. ELIZABETH HOME

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-03-0695

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

3/08/06

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

LOCH RAVEN VILLAGE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1827 LOCHSHIEL ROAD

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify:

WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

AERONAUTICAL ENGINEER

16b. Kind of Business/Industry

NASA

17. Father's Name (First, Middle, Last)

WILLIAM J. DEIMEL

18. Mother's Name (First, Middle, Maiden Surname)

FRANCES A. HARTEL

19a. Informant's Name/Relationship (Type, Print)

FRAN PELUSO

NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1827 LOCHSHIEL ROAD BALTIMORE, MD 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MOST HOLY REDEEMER CEM.

Date

11/19/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D32158

29d. Date signed (Month, Day, Year)

11/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tyotin Parkins, 821 N. Eutaw St, Suite 407, Baltimore, MD 21201.

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NOV 5 1940

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36383

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Denney

2. Date of Death

November 20 1999

3. Time of Death

3:03 AM

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

220-18-4144

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
9/4/1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

103 Fernglen Avenue

10f. Zip Code

21061

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Maximillion Mannel

18. Mother's Name (First, Middle, Maiden Surname)

Mary Mayer

19a. Informant's Name/Relationship (Type, Print)

James Emmett Denney (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 Fernglen Avenue Glen Burnie, MD 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Glen Haven Memorial Park

Date

11/23

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

Michael C. Jaffar

22. Name and Address of Facility

Singleton Funeral Home PA
1 Second Avenue S. W. Glen Burnie, MD 2106123a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause of each line.Immediate Cause (Final
disease or condition
resulting in death)

a. METABOLIC ACIDOSIS

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

50 DAYS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. HYPOXEMIA

Due to (or as a consequence of):

5 DAYS

c. GASTROINTESTINAL BLEED

Due to (or as a consequence of):

50 DAYS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael C. Jaffar HOUSE STAFF

29c. License number

BC 5572175

29d. Date signed (Month, Day, Year)

NOV 20 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BINU CHACKO, 301 HOSPITAL DRIVE, GLENBURNIE, MD 21061

State
Registrar

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

B. Sparks

Denney, Ruth
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36384

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
DirectorPhysician
/Medical
Examiner

| | | | | | |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Danielle N. Dorsey | | 2. Date of Death Month NOVEMBER Day 17 Year 1999 | | 3. Time of Death 1150 AM | |
| 4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| 5. Social Security Number 218-11-8999 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 13 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Apr 30, 1986 |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number 1711 North Broadway | | | 10f. Zip Code 21213- | | 10g. Citizen of What Country? United States |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Black | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student | | 16b. Kind of Business/Industry Baltimore City Public Schools | |
| 17. Father's Name (First, Middle, Last) Daniel Lewis Dorsey | | | 18. Mother's Name (First, Middle, Maiden Surname) Michelle Davis | | |
| 19a. Informant's Name/Relationship (Type, Print) Michelle Davis-Mother | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1711 N. Broadway Street, Baltimore, MD 21213 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial Park | | 20c. Location - City or Town, State Baltimore, MD | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASTHMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) NOVEMBER 18, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Howell Wake, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature  | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36385

| | | | | | | | | |
|--|--|-------------|---|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Shirley Derr | | | | 2. Date of Death Month Nov Day 11 Year 99 | | 3. Time of Death 16:55 | |
| | 4a. Facility Name (If not institution, give street and number) St. Agnes Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 057-18-0687 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 75 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Nov 19, 1923 | 9. Birthplace (State or Foreign Country) NY |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 719 Maiden Choice Lane HR622 | | | | 10f. Zip Code 21228 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | | 16b. Kind of Business/Industry Public Relations | |
| 17. Father's Name (First, Middle, Last) Charles Block | | | | 18. Mother's Name (First, Middle, Maiden Surname) Charlotte Gimbel | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Earl Derr/husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719 Maiden Choice Lane HR622, Baltimore, MD 21228 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Septic shock Due to (or as a consequence of): Acute cholecystitis Due to (or as a consequence of): Cotitis Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death 1 day 9 days 4 days |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier A. Averbach, M.D. | | | | 29c. License number UP-11695 | | | 29d. Date signed (Month, Day, Year) Nov 11, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Averbach, M.D., 900 Caton Av., Baltimore, MD 21229 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | | 32. Registrar's Signature B. Sparks | | | | | |

KIRK

EDWARDS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36386

| | | | | | | | | |
|---|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Kirk Anthony Edwards | | | | 2. Date of Death Month Day Year NOVEMBER 18, 1999 | | 3. Time of Death 3:36 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) 608 WALKER AVE | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 220-60-4248 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 41 Yrs. | | 8. Date of Birth (Month, Day, Year) 10-02-58 | |
| | Usual Residence of Decedent | | 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 1606 E. Monument Street | | 10f. Zip Code 21205 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (14 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance | | 16b. Kind of Business/Industry in & out of Home | | | | |
| 17. Father's Name (First, Middle, Last) Donald Garland | | | | 18. Mother's Name (First, Middle, Maiden Surname) Barbara Edwards | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Barbara Edwards | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21205 1606 E. Monument Street Baltimore, Maryland | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens | | Date 11-23-99 | | 20c. Location - City or Town, State Dundalk, MD | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Crushed hands of head and neck Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 11/18/99 | | 28b. Time of Injury 1532 M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) IN AUTO | | 28d. Describe how injury occurred Suburban street | | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 608 Walker Ave | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) NOVEMBER 19, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. CARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

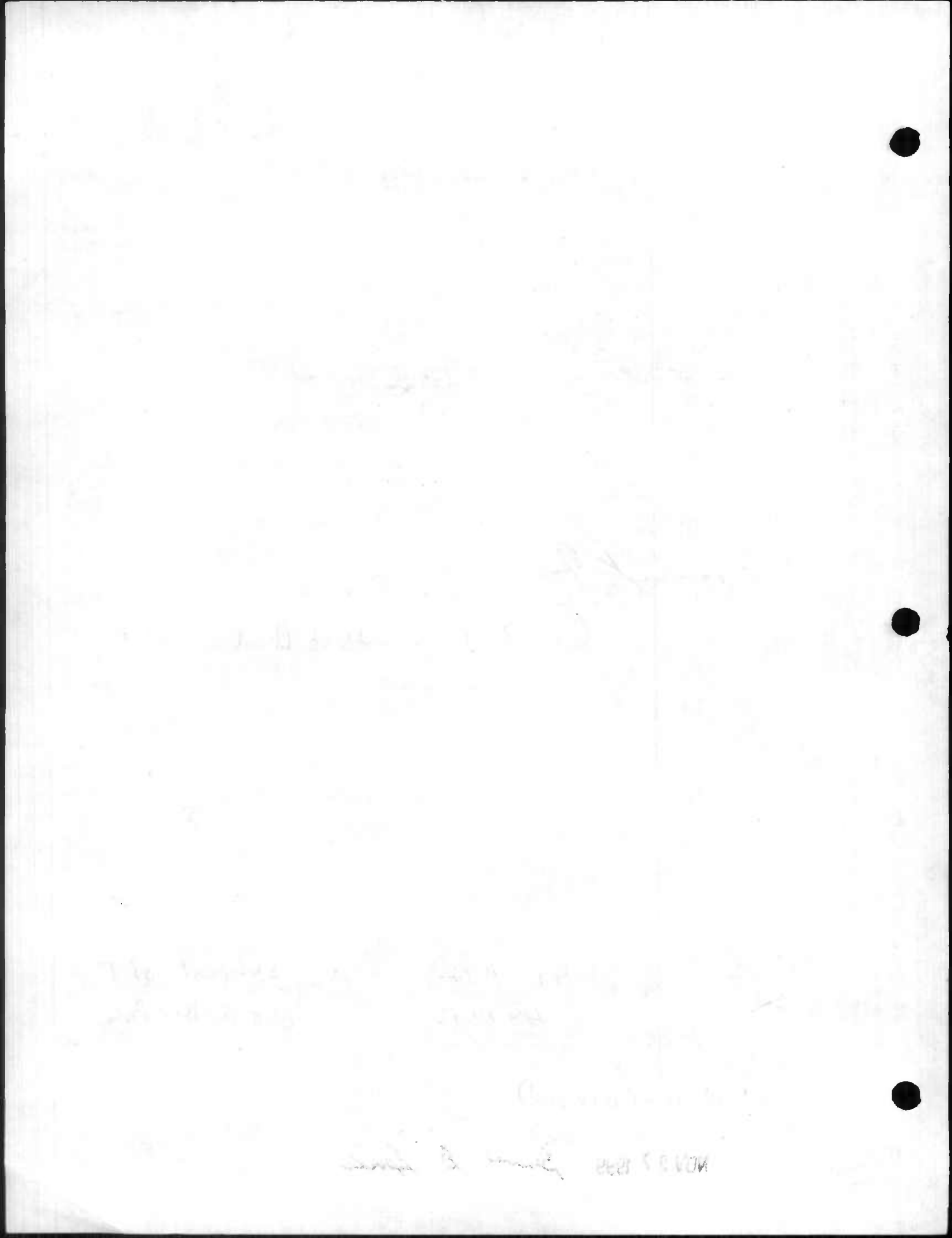
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36387

| | | | | | |
|--|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ARNOLD EDLAND | | 2. Date of Death Month Day Year NOVEMBER 16, 1999 | | 3. Time of Death 12:50 AM |
| | 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 212-07-8400 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 81 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) JUL. 11, 1918 | | 9. Birthplace (State or Foreign Country) MD | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location BALTIMORE | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 6930 BROOKMILL ROAD #T-1 | | | 10f. Zip Code 21208 | | 10g. Citizen of What Country? U.S.A. |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PROPRIETOR | | 16b. Kind of Business/Industry FURNITURE REFINISHING | |
| 17. Father's Name (First, Middle, Last) SAMUEL EDLAND | | 18. Mother's Name (First, Middle, Maiden Surname) MARY BESELL | | | |
| 19a. Informant's Name/Relationship (Type, Print) BARRY EDLAND / SON | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8917 MOUNTAINBERRY CIRCLE - FREDERICK, MD 21702 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MD VETERANS CEMETERY | | 20c. Location - City or Town, State 11/18/99 OWINGS MILLS, MD | |
| 21. Signature of Funeral Service Licensee <i>Scott M. Little</i> | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>Cardiorespiratory arrest</i></p> <p>Due to (or as a consequence of)</p> <p>b. <i>Arteriosclerotic cardiovascular disease</i></p> <p>Due to (or as a consequence of)</p> <p>c. <i>or</i></p> <p>Due to (or as a consequence of)</p> <p>d.</p> | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier <i>Howard B. (Chen)</i> | | 29c. License number D21680 | | 29d. Date signed (Month, Day, Year) 11/17/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6717 Park Heights Avenue Balto, Md. | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature <i>Benjamin A. Spatz</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 224-2248.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

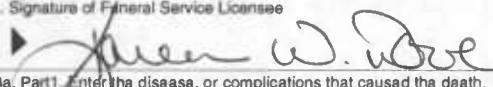
NOV 8 1968

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36388

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ISAAC A. ECKARD | | | | 2. Date of Death Month 11 Day 05 Year 99 | | 3. Time of Death 6:15 am | |
| | 4a. Facility Name (If not institution, give street and number) BALTIMORE VETERANS ADMINISTRATION HOSP. | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE CITY | |
| Funeral Director | 5. Social Security Number 234-46-6992 | | 6. Sex 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 27, 1930 | |
| | 9. Birthplace (State or Foreign Country) Charleston, WV | | 10a. State VA | | 10b. County Rockingham | | 10c. City, Town or Location Harrisonburg | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number Route 6 Box 209 | | 10f. Zip Code 22801 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1-23-52 2-25-52 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 6 College (1-4or 5+): | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self Employed | | 16b. Kind of Business/Industry Roofing Company | | | |
| | 17. Father's Name (First, Middle, Last) Jobe Eckard | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Jane Huffman | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Ethel V. Fink - Friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 6 Box 209 Harrisonburg, VA | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) East Lawn Mem. Gardens | | Data Nov. 8, 1999 | | 20c. Location - City or Town, State Harrisonburg, VA | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Capitol Funeral Service 7211 Lee Hwy Falls Church, VA 22046 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. MULTIPLE ORGAN SYSTEM FAILURE Dua to (or as a consequence of): b. RENAL CELL CANCER Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. Dua to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death |
| | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  MD | | 29c. License number AU47643589995 | | 29d. Date signed (Month, Day, Year) 11/05/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PERCY BATEY UNIVERSITY OF MD MEDICAL SYSTEM. DEPT. OF SURGERY | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36389

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician / Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)

DAVID EVANS

2. Date of Death

Month 10 Day 29 Year 99

3. Time of Death

7:50 PM

4a. Facility Name (If not institution, give street and number)

Maryland House of Correction Infirmary Jessup

4b. City, Town, or Location of Death

JESSUP MD

4c. County of Death

Anne Arundel

5. Social Security Number

unknown

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct 3, 1929

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

unknown

10b. County

unknown

10c. City, Town or Location

unknown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

unknown

10f. Zip Code

unknown

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates: unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

Collage (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Summa)

unknown

19a. Informant's Name/Relationship (Type, Print)

unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify) In State

20b. Place of Disposition (Name of cemetery, crematory or other place)

Data

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Retrocadiac Metastatic Tumor

Due to (or as a consequence of):

b. Renal Insufficiency

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Boateng

29c. License number

D46267

29d. Date signed (Month, Day, Year)

10/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Boateng, Maryland House of Correction Infirmary

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

P. Sparks

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36390

| | | | | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Jack Glenn Frank | | | | | | 2. Date of Death Month Day Year November 21, 1999 | | 3. Time of Death 8:00 A.M. | | | |
| | 4a. Facility Name (If not institution, give street and number) Gilchrist Center | | | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | | | |
| Funeral Director | 5. Social Security Number 216-32-9101 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 64 Yrs. | | 8. Date of Birth (Month, Day, Year) April 20, 1935 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Randallstown | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number 11 Cedar Hill Road | | | | 10f. Zip Code 21133 | | 10g. Citizen of What Country? United States | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Years: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) -0- | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PBX Telephone Installation | | | 16b. Kind of Business/Industry Telephone | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Adolph Frank | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Grace Glenn | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mrs. Evelyn Frank - Wife | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Cedar Hill Road; Randallstown, Maryland 21133 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Mem. Park | | 20c. Date 11/24/99 | | 20d. Location - City or Town, State Sykesville, Maryland | | | | | |
| | 21. Signature of Funeral Service Licensee | | | | | | 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133 | | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Colon cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death 6 years | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| | 29b. Signature and title of certifier | | | | | | 29c. License number 025205 | | 29d. Date signed (Month, Day, Year) November 21, 1999 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley GEMS 16701 Sparks Charles St. Balto. Md 21205 | | | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) NOV 22 1999 | | | | | | | | | | | |

ORIGINAL

NOV 28 1961

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36391

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|--|--|--------------------------------|---|--|
| 1. Decedent's Name (First, Middle, Last) JOHN FLEMING | | | | 2. Date of Death Month 11 Day 18 Year 99 | | 3. Time of Death 5:39 AM | |
| 4a. Facility Name (If not institution, give street and number) BON SECOURS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | |
| 5. Social Security Number 250-14-5643 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 80 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 01-19-19 | |
| 9. Birthplace (State or Foreign Country) SC | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number 3330 W. Wilkens Avenue | | | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Councilor | | 16b. Kind of Business/Industry Dept. Human Resources | |
| 17. Father's Name (First, Middle, Last) Henry Frank Fleming | | | | 18. Mother's Name (First, Middle, Maiden Surname) Fannie Ben | | | |
| 19a. Informant's Name/Relationship (Type, Print) Murray Fleming | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2306 Ashe Street Durham, NC 27703 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. John U.M. Church Cem. | | 20c. Location - City or Town, State 11-23-99 Lynchburg, SC | | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. BILATERAL PNEUMONIA Due to (or as a consequence of): b. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier Rosita R. Cruz M.D. | | | | 29c. License number D0030355 | | 29d. Date signed (Month, Day, Year) 11-18-99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROSITA R. CRUZ M.D. BON SECOURS HOSPITAL | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

AMEND#29d&30 PER MD. 6777 11-22-99 J.A.

99 36392

| | | | | | | | | | | |
|--|--|--|---|--|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Dolores Frances Freburger | | | | | | 2. Date of Death Month Day Year November 15, 1999 | | 3. Time of Death 4:12 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) 206 Glen Road | | | | | | 4b. City, Town, or Location of Death Pasadena | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 215 26 7553 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 67 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 17, 1931 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Pasadena | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 206 Glen Road | | | | 10f. Zip Code 21122 | | 10g. Citizen of What Country? U.S. | | | |
| | 11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | |
| | 17. Father's Name (First, Middle, Last) George C. Miller | | | | | | 18. Mother's Name (First, Middle, Maiden Summa) Agnes Corrigan | | | |
| | 19a. Informant's Name/Relationship (Type, Print) John Freburger / Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Glen Road Pasadena, Maryland 21122 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cemetery | | 20c. Location - City or Town, State 11/19/99 Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee <i>Donna M. Zramkowski</i> | | | | 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 | | | | | |
| | 23a. Part I. Enter the disease or diseases that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Lung Cancer Due to (or as a consequence of): b. Peritonitis with perforated viscus Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | | | | | | |
| 28a. Date of Injury (Month, Day Year) 11/19/99 | | | | | | | | | | |
| 28b. Time of Injury M | | | | | | | | | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 28d. Describe how injury occurred | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Chris DeBorja</i> | | | | | | | | | | |
| 29c. License number 042820 | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year) 11/16/99 | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRIS DeBORJA MD. 3708 MOUNTAIN ROAD PASADENA, MARYLAND 21122 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | | | | | | | | | |
| 32. Registrar's Signature <i>[Signature]</i> | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36393

| | | | | | | | | |
|---|---|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Raymond Anthony Faidley | | | | 2. Date of Death Month Day Year NOV. 16, 1999 | | 3. Time of Death 2045 PM | |
| | 4a. Facility Name (If not institution, give street and number) GREENMOUNT AVENUE & 24TH STREET | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 214-02-1248 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 20 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb 26, 1979 | |
| | Usual Residence of Decedent | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 1729 N. Washington Street | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unemployed | | 16b. Kind of Business/Industry N/A | | | |
| | 17. Father's Name (First, Middle, Last) Tyrone Recardo Faidley, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sheila Hoggard Faidley | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mrs. Sheila Faidley-Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1729 North Washington Street, Baltimore, MD 21213 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Memorial Park | | Data NOV 23 1999 | | 20c. Location - City or Town, State Baltimore, MD | |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | | | |
| | 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) 11/16/99 | | 28b. Time of Injury 2035M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred Subject Shot | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street; Greenmount + 24th St; Baltimore, Md. | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier  | | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) NOV. 17, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. AARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature  | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36394
Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|-----------------------------|--|--|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edgar A. Fendlay | | | | | | 2. Date of Death Month Day Year November 16 1999 | | 3. Time of Death 07:45 PM. | | |
| | 4a. Facility Name (If not institution, give street and number) North Arundel Hospital | | | | | | 4b. City, Town, or Location of Death Glen Burnie | | 4c. County of Death Anne Arundel | | |
| Funeral Director | 5. Social Security Number 218 56 2497 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 48 Yrs. | | 8. Date of Birth (Month, Day, Year) April 23, 1951 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Pasadena | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 1260 Rock Hill Road | | | | 10f. Zip Code 21122 | | 10g. Citizen of What Country? U.S. | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cleaner | | | 16b. Kind of Business/Industry Carpet | | | | |
| 17. Father's Name (First, Middle, Last) John E. Fendlay | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mildred G. Maher | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mildred Fendlay / Mother | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1260 Rock Hill Road Pasadena, Maryland 21122 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park | | | Date 11/20/99 | | 20c. Location - City or Town, State Glen Burnie, Maryland | | | |
| 21. Signature of Funeral Service Licensee <i>Jerome Znamkowski</i> | | | | | | 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 | | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Multiple injuries</i> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) 6/6/99 | | 28b. Time of Injury 1:35 PM | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Subject bicyclist struck by vehicle | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) roadway | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Fruitwood Road + Farmview Road Pasadena Maryland | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | 29b. Signature and title of certifier <i>Thaddeus M. King</i> | |
| 29c. License number O.C.M.E. | | | 29d. Date signed (Month, Day, Year) November 18, 1999 | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Thaddeus M. King</i> 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 20 1999 | | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36395

Physician
(Medical
Examiner)

1. Decedent's Name (First, Middle, Last)

Margaret E. Gray

2. Date of Death
Month Day Year

Nov. 8, 1999

3. Time of Death
1840

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

216-34-9962

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month Day Year)

March 4, 1920

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

MD

10b. County

Queen Annes

10c. City, Town or Location

Centerville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

205 Armstrong Avenue

10f. Zip Code

21617

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (14 or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Mary Brinkley/friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 156 Grasonville, MD 21638

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Cardiomyopathy

Approximate Interval Between Onset and Death

3 yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

Arteriosclerotic heart disease

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. S. Wade

29c. License number

032036

29d. Date signed (Month, Day, Year)

11/9/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary T. Sprauze 2109 N. Donah Drive Chester, MD 21619

State
Registrar

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36396

Certificate of Death

Reg. No.

Haywood John
 Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

| | | | | | | | |
|---|--|---|---|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) JOHN J. HAYWOOD, SR. | | | | 2. Date of Death Month Day Year NOV. 18, 1999 | | 3. Time of Death 12:39am | |
| 4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | 4c. County of Death AACOUNTY | |
| 5. Social Security Number 216-30-5592 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 77 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) APRIL 4, 1922 | |
| 9. Birthplace (State or Foreign Country) ALABAMA | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location SEVERN | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 748 EVERGREEN ROAD | | | | 10f. Zip Code 21144 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-1946 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPERVISOR | | 16b. Kind of Business/Industry U. S. GOVERNMENT | |
| 17. Father's Name (First, Middle, Last) JOHN J. HAYWOOD | | | | 18. Mother's Name (First, Middle, Maiden Surname) EMMA O'DONNELL | | | |
| 19a. Informant's Name/Relationship (Type, Print) FRANCES HAYWOOD (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 748 EVERGREEN ROAD, SEVERN, MD. 21144 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK | | Date 11/20/99 | | 20c. Location - City or Town, State GLEN BURNIE, MD. | |
| 21. Signature of Funeral Service Licensee <i>Paul J. Haywood</i> | | | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | |

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|--|--|--|--|
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>acute myocardial infarction</i> Due to (or as a consequence of): b. <i>coronary artery disease</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 1 day 15 years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier <i>Charles J. W. W.</i> | | 29c. License number D18508 | | 29d. Date signed (Month, Day, Year) 11-18-99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles J. W. W. 1600 S. Crein Highway #106 Glen Burnie 21061 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature <i>Sparks</i> | | | |

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36397

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | |
|---|---|--|---|---------------------------------|--|--|--------------------------------|--|--|---|---|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John Harris | | | | 2. Date of Death Month Day Year September 04, 1999 | | | | 3. Time of Death 7:17 A.M. | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 917 Stoll Street | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | | | | | | | |
| Funeral Director | 5. Social Security Number unknown | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 74 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) March 25, 1925 | | 9. Birthplace (State or Foreign) unknown | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore City | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | 10e. Street and Number 917 Stoll Street | | | | 10f. Zip Code 21225 | | | | 10g. Citizen of What Country? USA | | | | | | | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: unknown | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unknown unknown | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown | | | | 16b. Kind of Business/Industry unknown | | | | | | | |
| | 17. Father's Name (First, Middle, Last) unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname) unknown | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) O.C.M.E. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201 | | | | | | | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Date | | | | 20c. Location - City or Town, State | | | | | | | |
| | 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| | Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | |
| | | | | | | | | | | 24a. Was an autopsy performed? Inspection 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier J. Laron Locke M.D. | | | | 29c. License number O.C.M.E. | | | | 29d. Date signed (Month, Day, Year) November 15, 1999 | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year) NOV 22 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36398

| | | | | | | | | | |
|---|---|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Fred Indig | | | | 2. Date of Death Month November Day 21 Year 1999 | | 3. Time of Death 10:10 A.M. | | |
| | 4a. Facility Name (If not Institution, give street and number) St. Agnes Nursing and Rehabilitation Cntr. | | | | 4b. City, Town, or Location of Death Ellicott City | | 4c. County of Death Howard | | |
| Funeral Director | 5. Social Security Number 089-28-2815 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 89 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Feb. 8, 1910 | 9. Birthplace (State or Foreign Country) Romania | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State Maryland | | 10b. County Howard | | 10c. City, Town or Location Ellicott City | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 10121 Spring Thaw Ct. | | | | 10f. Zip Code 21042 | | 10g. Citizen of What Country? United States | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Broker | | | 16b. Kind of Business/Industry Real Estate | | |
| 17. Father's Name (First, Middle, Last) Schlmo Zui | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rachel Unknown | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Jack Indig / son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10121 Spring Thaw Ct. Ellicott City, MD. 21042 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) New Montifiore Cemetery | | Date Nov. 23 1999 | | 20c. Location - City or Town, State Long Island, New York | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. RENAL FAILURE Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE Due to (or as a consequence of): c. HYPERTENSION Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death 1 YR. | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | | 29c. License number D42680 | | 29d. Date signed (Month, Day, Year) 11-22-1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SABA S. STEIKH M.D. 9051 BALF. NATL. PIKE ELlicott City MD 21042 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | | 32. Registrar's Signature  | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

NOV 2 1931

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36399

| | | | | | | | | | | | |
|---|---|---|--|---|---|--------------------------------------|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Howard M. Iser | | | | 2. Date of Death Month Day Year NOVEMBER 12, 1999 | | | | 3. Time of Death 7:00 AM | | |
| | 4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital | | | | 4b. City, Town, or Location of Death Cumberland | | | | 4c. County of Death Allegheny | | |
| Funeral Director | 5. Social Security Number 214-68-7095 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) June 24, 1922 | | 9. Birthplace (State or Foreign Country) WV | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County Allegheny | | 10c. City, Town or Location Cumberland | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 1 Kaylor Circle | | | | 10f. Zip Code 21532 | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 40-46 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plumber | | | | 16b. Kind of Business/Industry Plumbing | | | |
| 17. Father's Name (First, Middle, Last) Newton F. Iser | | | | 18. Mother's Name (First, Middle, Maiden Surname) Edna G. Fadley | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Francis Fuller/sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown | | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | | | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | | | | | |
| 23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. HYPERTENSION Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death 3 DAYS 710 YEARS | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier Chang Oh, M.D. | | | | 29c. License number D24951 | | | | 29d. Date signed (Month, Day, Year) NOVEMBER 12, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANG OH, M.D. 48 TARN TERRACE FROSTBURG MD 21532 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36400

| | | | | | | | | |
|--|--|-------------------|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Roskey Lee Johnson, Sr. | | | | 2. Date of Death Month Day Year Nov. 15, 99 | | 3. Time of Death 10:05pm | |
| | 4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Ctn. | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NA | |
| Funeral Director | 5. Social Security Number 242-58-6998 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 62 Yrs. | | 8. Date of Birth (Month, Day, Year) 05-14-37 | |
| | | | | | | | 9. Birthplace (State or Foreign Country) NC | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 4904 Aberdeen Avenue | | | | 10f. Zip Code 21206 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5th Grade NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction worked | | | 16b. Kind of Business/Industry Construction Co. | |
| 17. Father's Name (First, Middle, Last) Carey White | | | | 18. Mother's Name (First, Middle, Maiden Surname) Alma Johnson 21206 | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Renea Johnson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4904 Aberdeen Avenue Baltimore, Maryland | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery 11-20-99 | | 20c. Location - City or Town, State Lansdowne, MD | | | |
| 21. Signature of Funeral Service Licensee <i>Joseph R. Walter, Jr.</i> | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Diffuse Metastasis from cancer Smooth Due to (or as a consequence of): b. Non small lung cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28d. Describe how injury occurred | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Victor M. Moyo M.D.</i> | | | | 29c. License number AJ 6167357P8634 | | 29d. Date signed (Month, Day, Year) 11/19/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Victor M. Moyo Johns Hopkins Hospital 600 N. Wolfe Street MD 21287 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | | 32. Registrar's Signature <i>Benita B. Spauls</i> | | | | | |

Handwritten signature

PROB. & S. VON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36401

Funeral Director

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Stuart Thomas Johnson

2. Date of Death

November 16, 1999

3. Time of Death

9:25 A.M.

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

214-62-9027

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

45

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

09-14-54

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4638 Marble Hall Road

10f. Zip Code

21239

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

2 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Full-time

16b. Kind of Business/Industry

Living Classroom Foundation

17. Father's Name (First, Middle, Last)

George Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Carrie M. Freeman

19a. Informant's Name/Relationship (Type, Print)

Carrie M. Freeman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4638 Marble Hall Road Baltimore, MD 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest VA Cem. 11-23-99 Owings Mills,

Date

20c. Location - City or Town, State

MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

DIABETIC KETOACIDOSIS

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

November 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36402

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) BERNICE JANNEY | | | | 2. Date of Death Month Day Year NOVEMBER 15, 1999 | | 3. Time of Death 9:00 PM | |
| 4a. Facility Name (If not institution, give street and number) JEWISH CONVALESCENT CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE | |
| 5. Social Security Number 217-46-0042 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) JAN. 31, 1915 | |
| 10a. State FL | | 10b. County PINELLAS CO. | | 10c. City, Town or Location ST. PETERSBURG | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 1255 PASADEN AVE. SOUTH #1002 | | | | 10f. Zip Code 33707 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME | |
| 17. Father's Name (First, Middle, Last) MOSES | | | | 18. Mother's Name (First, Middle, Maiden Surname) ANNA SHULMAN | | | |
| 19a. Informant's Name/Relationship (Type, Print) JAY JANNEY / SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3716 BRENTFORD ROAD - RANDALLSTOWN, MD 21133 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON CHIZUK AMUNO | | Date 11/17/99 | | 20c. Location - City or Town, State BALTIMORE, MD | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | |

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebral Thrombosis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 2 months | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. severe hypoalbuminemia | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) N/A | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D15872 | | 29d. Date signed (Month, Day, Year) November 16, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 Main St. Reisterstown Maryland 21136 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature | | | |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

NOTE TO THE READER
COPY 2 OF 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36403

AMEND#23a.26-28f PER M.F.O. G777 11-22-99 J.A.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Shimieka Nicole Jenkins

2. Date of Death

November 03, 1999 1:17 P.M.

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-53-2115

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

1

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 15, 1998

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

110 Shropshire Court

10f. Zip Code

21136

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (14 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Never Employed

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Nathaniel L. Lee

18. Mother's Name (First, Middle, Maiden Surname)

Shimieka N. Jenkins

19a. Informant's Name/Relationship (Type, Print)

Ms. Shimieka N. Jenkins Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

110 Shropshire Court Reisterstown, MD 21136

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evergreen Mem. Park

Date

11/8

20c. Location - City or Town, State

Finksburg, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.

8728 Liberty Road Randallstown MD 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

SMOKE INHALATION AND THERMAL INJURIES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☒ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

11-03-1999

28b. Time of Injury

11:04 AM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

SUBJECT INHALED

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

110 Shropshire Ct. Baltimore, Maryland.

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

November 04, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

B Spade

State
Registrar

Baltimore, Maryland 21215-0020

pemit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed with 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit.

(A)

Handwritten signature and text: "Handwritten signature" and "Page 1 of 100"

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36404

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Yun W. Kim

2. Date of Death

November 20 1999

3. Time of Death

3:00 P.M.

4a. Facility Name (If not institution, give street and number)

8053 Greenleaf Terrace Apt. 23

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

None

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Aug. 20, 1917

9. Birthplace (State or Foreign Country)

South Korea

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8053 Greenleaf Terrace Apt. 23

10f. Zip Code

21061

10g. Citizen of What Country?

South Korea

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Korean

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
unknown

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Sung Yi Kim

18. Mother's Name (First, Middle, Maiden Surname)

Kum Dong Kang

19a. Informant's Name/Relationship (Type, Print)

Yong Chae

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8053 Greenleaf Terrace Apt. 23 Glen Burnie, Md. 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Holy Cross Cemetery

Date

11/26/99 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 2122523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Probable Gastric Cancer
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D25654

29d. Date signed (Month, Day, Year)

11/22/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YEON G OH 1412 Crain HW N GB MD 21061

31. Date filed (Month, Day, Year)

NOV 20 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36405

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles F. Koppisch

2. Date of Death
Month Day Year
NOV 17 1999
3. Time of Death
17:11

4a. Facility Name (If not institution, give street and number)

ST. AGNES HEALTH CARE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director5. Social Security Number
215-01-41006. Sex
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)
88 Yrs.If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)
Mar 7, 19119. Birthplace (State or Foreign
Country)
WV

Usual Residence of Decedent

10a. State
MD10b. County
N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits
☒ Yes 2 ☐ No

10e. Street and Number

719 Maiden Choice Lane

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.
Specify:

White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
416a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Aerospace

17. Father's Name (First, Middle, Last)

Charles F. Koppisch

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Butler

19a. Informant's Name/Relationship (Type, Print)

Barbara Griffin/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

415 Radcliff Rd, Dewitt, NY 13214

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

STROKE

Approximate
Interval Between
Onset and Death

DAYS

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SPINAL CORD CONTUSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Bonnie MD.

29c. License number

P13595

29d. Date signed (Month, Day, Year)

NOV. 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST. AGNES HOSPITAL BALTIMORE MD 21229, GEORGE BAFFOE-BONNIE

State
Registrar

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitNAME CHARLES KOPPISCH
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: #23 PARTI, 27, 28A-F PER MEO G777 11-18-99 WR. 99 36406

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|---|---|---|--|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) David William Krystkiewicz | | | | 2. Date of Death Month Day Year October 13, 1999 | | | | 3. Time of Death 04:32 AM | | |
| | 4a. Facility Name (If not institution, give street and number) 4221 Kenwood Avenue | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 220-06-6649 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 29 Yrs. | | 8. Date of Birth (Month, Day, Year) 01/26/1970 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 4221 Kenwood Avenue | | | | 10f. Zip Code 21206 | | 10g. Citizen of What Country? U.S.A. | | | | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpet Installer | | | | 16b. Kind of Business/Industry Carpet Contractor | | | |
| 17. Father's Name (First, Middle, Last) Karol Krystkiewicz | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Regina Nolker | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary B. Krystkiewicz | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4221 Kenwood Avenue Baltimore, Maryland 21206 | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Balto/Wash. Crematory | | Date 10/18/99 | | 20c. Location - City or Town, State Laurel, Maryland | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ETHYLENE GLYCOL INTOXICATION a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 10-13-99 | | 28b. Time of Injury UNKNOWN | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred SUBJECT DRANK ANTI-FREEZE | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HOME | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4221 KENWOOD AVE BALTIMORE, MARYLAND | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) October 13, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, MD 111 Penn St. Balto MD 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | 32. Registrar's Signature | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

NOV 1 1980

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36407

AMEND#9 PER A.B. G777 11-22-99 J.A.

| | | | | | | | | | | |
|---|---|--|---|--|---|--|---|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>William Knight</i> | | | | | 2. Date of Death Month <i>10</i> Day <i>21</i> Year <i>99</i> | | 3. Time of Death <i>7:55 AM</i> | | |
| | 4a. Facility Name (If not institution, give street and number) <i>Ravenwood Nursing Home</i> | | | | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | 4c. County of Death <i>N/A</i> | | |
| Funeral Director | 5. Social Security Number <i>238-40-6224</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>76</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>Sept 30, 1923</i> | | 9. Birthplace (State or Foreign Country) <i>NORTH CAROLINA</i> | |
| | Usual Residence of Decedent | | | | | 10a. State <i>MD</i> | | 10b. County <i>N/A</i> | | 10c. City, Town or Location <i>Baltimore</i> |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | 10e. Street and Number <i>1120 E. Baltimore Street</i> | | 10f. Zip Code <i>21201</i> | | 10g. Citizen of What Country? <i>USA</i> | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>unknown</i> College (1-4 or 5+) <i>unknown</i> | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>unknown</i> | | | 16b. Kind of Business/Industry <i>unknown</i> | | |
| 17. Father's Name (First, Middle, Last) <i>James McKnight</i> | | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Minnie Autry</i> | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Dwight Warren/friend</i> | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1120 E. Baltimore Street Baltimore, MD 21201</i> | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <i>in state</i> | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | | 20c. Location - City or Town, State | | | | |
| 21. Signature of Funeral Service Licensee <i>Ronald S. Wade, Director</i> | | | | | 22. Name and Address of Facility <i>Anatomy Board, 655 W. Baltimore Street, Baltimore, MD 21201</i> | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | |
| <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>Metastatic Gastric Cancer</i></p> <p>Due to (or as a consequence of):</p> <p>b. _____</p> <p>Due to (or as a consequence of):</p> <p>c. _____</p> <p>Due to (or as a consequence of):</p> <p>d. _____</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how Injury occurred | | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Aga Ahmed M.D.</i> | | | | | 29c. License number <i>D39127</i> | | 29d. Date signed (Month, Day, Year) <i>11/16/99</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>A-AHMED 821 N. Eulaw Street Baltimore MD 21201</i> | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>NOV 22 1999</i> | | | | | 32. Registrar's Signature <i>Brenda B. Sparks</i> | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

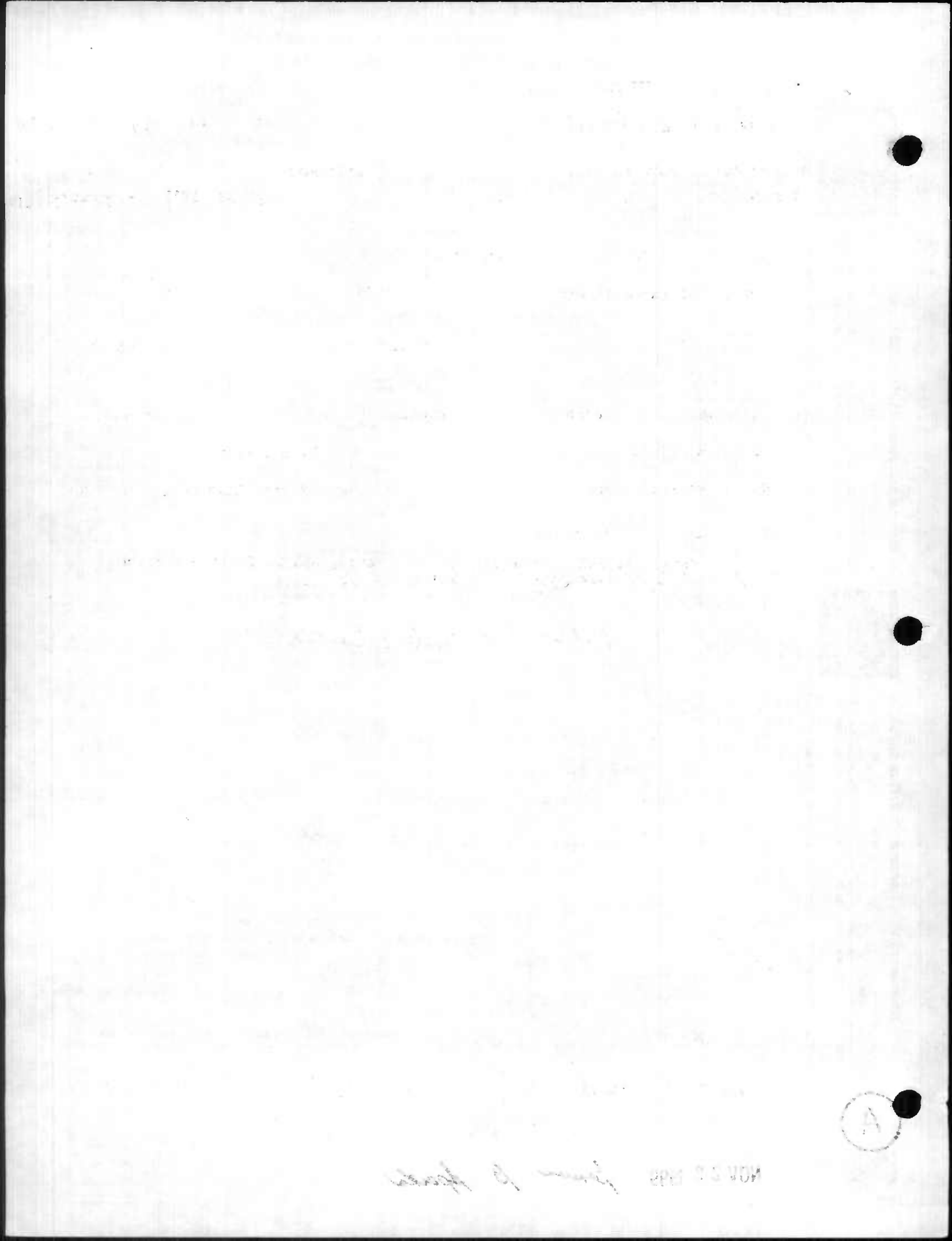
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

A



[Handwritten signature]

JAN 28 1982

A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36408

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | | |
|--|--|---|---|--|--|--|--|-----------------------------------|--|
| 1. Decedent's Name (First, Middle, Last) Hattie Elizabeth Lee | | | | | | 2. Date of Death Month Day Year November 16, 1999 | | 3. Time of Death 10:00 A.M. | |
| 4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death Baltimore | | | |
| 5. Social Security Number 214-18-5987 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 79 Yrs. | 8. Date of Birth (Month, Day, Year) 07-18-20 | 9. Birthplace (State or Foreign Country) MD | | | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number 3818 Rexmere Road | | | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (14 or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk | | | 16b. Kind of Business/Industry Motor Vehicle Admin | | |
| 17. Father's Name (First, Middle, Last) Edward Thomas | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sadie Henry | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Brenda Player | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 3818 Rexmere Road Baltimore, Maryland | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens | | 20c. Location - City or Town, State 11-22-99 Dundalk, MD | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Methicillin Resistant Staphylococcus Aureus, Bacteremia Due to (or as a consequence of): c. Pneumonia, Central line Sepsis Due to (or as a consequence of): d. End Stage Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Malnutrition, Coronary Artery Disease Ischemic Cardiomyopathy | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number D38754 | | 29d. Date signed (Month, Day, Year) November 16, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Malika Waseem, M.D. 9000 Franklin Square Drive, Baltimore MD. 21237 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Handwritten signature

2221 S. 2 VON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36409

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HARRY

LIEBMAN

2. Date of Death

November 9, 1999

3. Time of Death

4:55 p.m.

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

218-14-0646

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

SEPT. 21, 1912

9. Birthplace (State or Foreign Country)

GERMANY

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6 FARRINGTON CT.

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OWNER

16b. Kind of Business/Industry

BUILDING MATERIALS

17. Father's Name (First, Middle, Last)

SOLLY

LIEBMAN

18. Mother's Name (First, Middle, Maiden Surname)

RECHA

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

RONALD LIEBMAN (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1615 31ST NW WASHINGTON, DC 20007

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHEVRA AHAVAS CHESED

Date

11/11/99

20c. Location - City or Town, State

RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee

Scott M. Gutter

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Urosepsis

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

C. Earl Grant

29c. License number

Res-000

29d. Date signed (Month, Day, Year)

November 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. Earl Grant, Sinai Hospital, 2401 W. Belvedere Ave., Baltimore 21215

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

Benita B. Sparks

State
RegistrarHarry Liebman
Baltimore, Maryland 21215-0020Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020

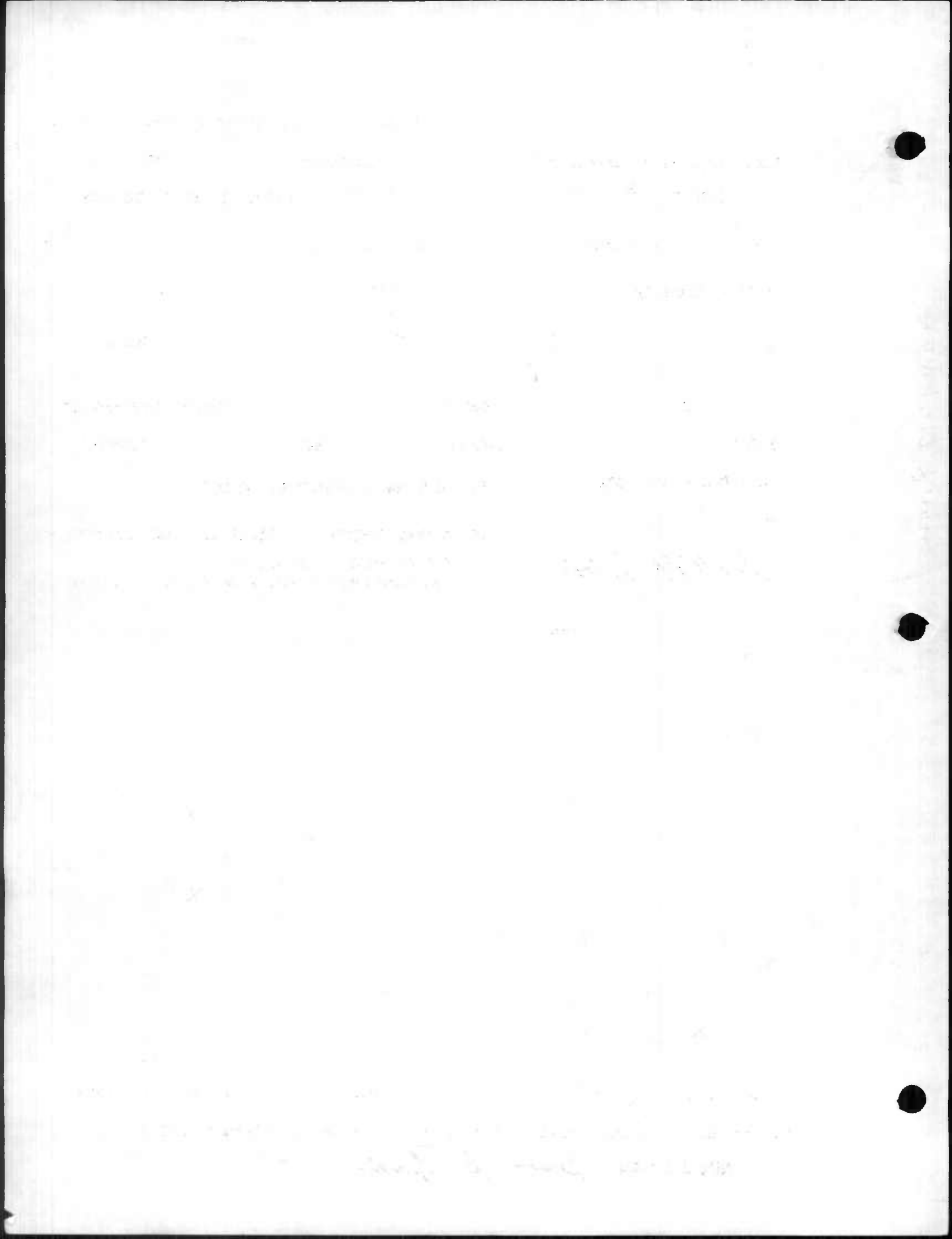
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36410

| | | | | | | | | |
|---|---|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Anna H. Lozoskie | | | | 2. Date of Death Month Day Year November 18, 1999 | | 3. Time of Death 2:15 AM | |
| | 4a. Facility Name (If not institution, give street and number) St Elizabeths Rehab & Nursing Center | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore City | |
| Funeral Director | 5. Social Security Number 218-28-5413 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug 21 1909 | |
| | 9. Birthplace (State or Foreign Country) PA | | Usual Residence of Decedent | | 10a. State MD | | 10b. County Baltimore | |
| To Be Completed by Funeral Director | 10c. City, Town or Location Dundalk | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 7825 Kentley Rd | | 10f. Zip Code 21222 | |
| | 10g. Citizen of What Country? USA | | 11. Mental Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| To Be Completed by Physician/Medical Examiner | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Collega (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | |
| | 17. Father's Name (First, Middle, Last) Thomas Benedict | | 18. Mother's Name (First, Middle, Maiden Surname) Martha Bastas | | 19a. Informant's Name/Relationship (Type, Print) Ann Mastroianni /daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7825 Kentley Rd Baltimore, MD 21222 | |
| Physician /Medical Examiner | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Jesus | | 20c. Location - City or Town, State Baltimore, MD | | 20d. Date Nov 22 | |
| | 21. Signature of Funeral Service Licensee Anthony C. Connelly | | 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 | | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atherosclerotic Cardiovascular Disease | | Approximate Interval Between Onset and Death years | |
| To Be Completed by Physician/Medical Examiner | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Senile Dementia | | 23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| State Registrar | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and Title of Certifier Barthuis | |
| | 29c. License number D32158 | | 29d. Date signed (Month, Day, Year) 11/18/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tyoti Parikh, 821 N. Eutaw St, suite 407, Baltimore, MD 21201 | | 31. Date filed (Month, Day, Year) NOV 22 1999 | |
| 32. Registrar's Signature B Sparks | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Handwritten signature

NOV 1 1953

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36411

amend item 1, 3, 4a, 10e, 16a, 17, 18
per informant 6780 2/9/00 yg per fh, Phys.

| | | | | | | | | |
|---|---|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Franklin Longfellow Franklin David Longfellow | | | | 2. Date of Death Month Day Year November 13, 1999 | | 3. Time of Death 2:20 pm | |
| | 4a. Facility Name (If not institution, give street and number) Gilchrist Center Hospice of Baltimore Gilchrist | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 552-05-4447 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) March 6, 1916 | |
| | 9. Birthplace (State or Foreign Country) Canada | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Towson | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10f. Zip Code 21204 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Management Maintenance Supervisor | | 16b. Kind of Business/Industry Oil Industry | |
| | 17. Father's Name (First, Middle, Last) Elwood Irwin Longfellow | | | | 18. Mother's Name (First, Middle, Maiden Surname) Nettie Dale | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Susan Randall/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14242 Cuba Road Cockeysville, MD 21030 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) in state | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) in state | | 20c. Location - City or Town, State | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. metastatic cancer of uncertain primary site | | | | Approximate Interval Between Onset and Death | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Anthony Riley, MD | | | |
| | 29c. License number 025205 | | | | 29d. Date signed (Month, Day, Year) November 14, 1999 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley GMC 6201 N. Charles St. Balto. MD 21207 | | | | 31. Date filed (Month, Day, Year) NOV 22 1999 | | | |
| | 32. Registrar's Signature James B. Sparks | | | | 33. State Registrar NOV 22 1999 | | | |

ORIGINAL

MOA 5 5 1955

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland/ Department of Health and Mental Hygiene

AMEND#516a,b, &20a-20c PER F.H. G778 12-14-99 **Certificate of Death**

Reg. No.

99 36412

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | |
|---|--|---|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Elizabeth Lester | | | | 2. Date of Death Month Day Year November 7, 1999 | | 3. Time of Death 16:38 pm | | |
| 4a. Facility Name (If not institution, give street and number) 830 Herndon Court | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | |
| 5. Social Security Number 219-32-3909 unknown | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 61 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan 25, 1938 | | |
| 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 830 Herndon Court | | 10f. Zip Code 21225 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: unknown | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4or 5+) unknown | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME unknown | | | | |
| 17. Father's Name (First, Middle, Last) unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname) unknown | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Miss Lucas/friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY INC. | | Date 12/14/99 | | 20c. Location - City or Town, State BALTIMORE, MD. | | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. STROKE Due to (or as a consequence of): b. CEREBROVASCULAR DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. | | | | | | | Approximate Interval Between Onset and Death 1d 1 yr. | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier [Signature] | | 29c. License number 015640 | | 29d. Date signed (Month, Day, Year) 11/8/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARC S. POSNER MD 1147 S. HANOVER ST. | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature [Signature] | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and must be filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

(A)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

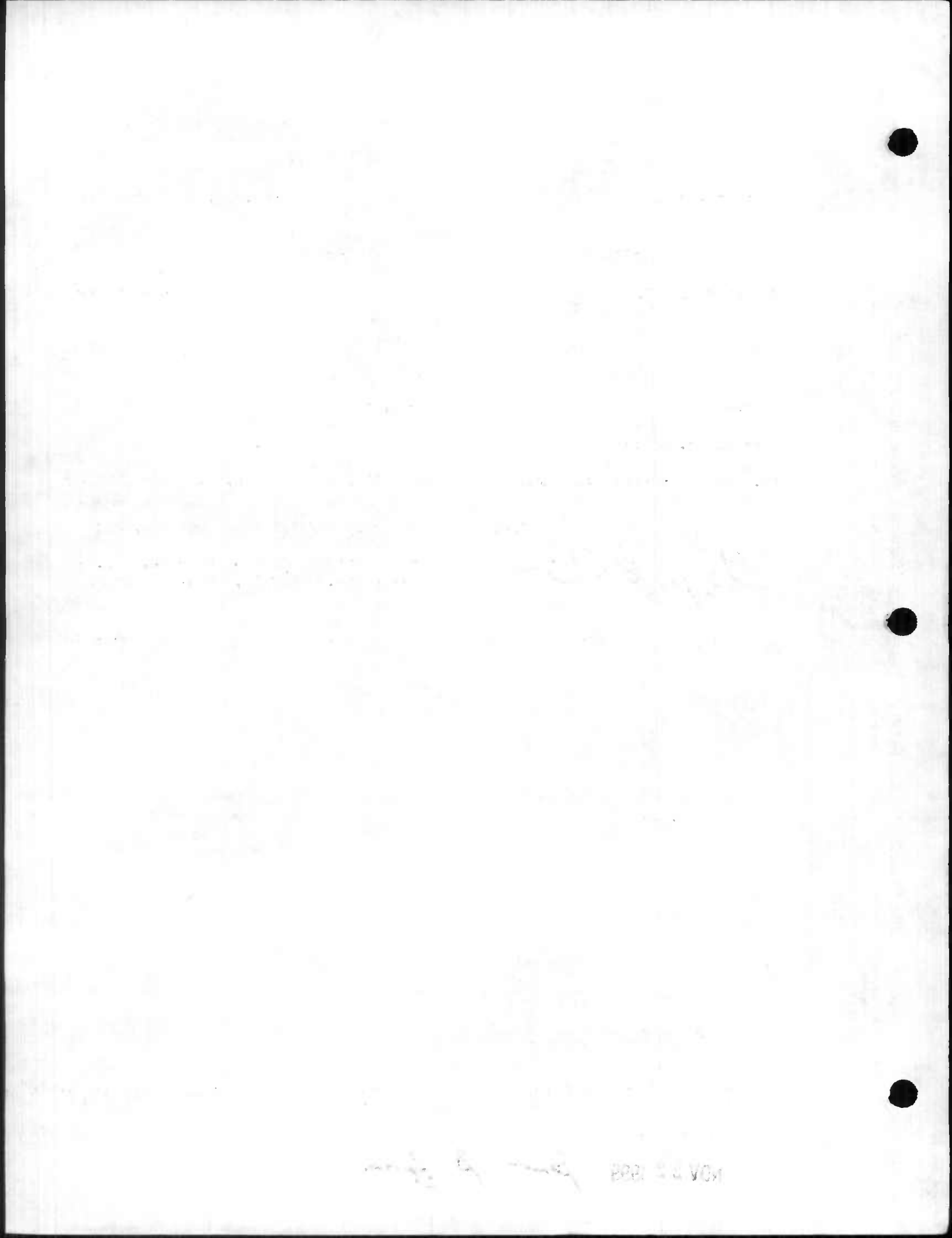
99 36413

| | | | | | | | | |
|---|---|---|--|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Kay Mayhorne</i> | | | | 2. Date of Death Month <i>November</i> Day <i>18</i> Year <i>1999</i> | | 3. Time of Death <i>12:28 am</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>Johns Hopkins Bayview Medical Center</i> | | | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | 4c. County of Death <i>N/A</i> | |
| Funeral Director | 5. Social Security Number <i>217-40-1339</i> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>55</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>Aug. 17, 1944</i> | 9. Birthplace (State or Foreign Country) <i>Maryland</i> |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State <i>Maryland</i> | | 10b. County <i>Baltimore</i> | | 10c. City, Town or Location <i>Dundalk</i> | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number <i>9 German Hill Road</i> | | | | 10f. Zip Code <i>21222</i> | | 10g. Citizen of What Country? <i>United States</i> | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11 Years</i> College (1-4 or 5+) <i>College</i> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i> | | 16b. Kind of Business/Industry <i>Own Home</i> | | |
| 17. Father's Name (First, Middle, Last) <i>Francis E. Hewitt</i> | | | | 18. Mother's Name (First, Middle, Maiden Summa) <i>Louise W. Webster</i> | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Mr. Davis Mayhorne (Husband)</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9 German Hill Road Dundalk, Maryland 21222</i> | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Craigsville Cemetery</i> | | Data <i>11/20/1999</i> | | 20c. Location - City or Town, State <i>Augusta, VA</i> | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</i> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Small Cell Carcinoma of the lung</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. _____ Due to (or as a consequence of):</i> <i>c. _____ Due to (or as a consequence of):</i> <i>d. _____</i> | | | | | | | | Approximate Interval Between Onset and Death <i>1 month</i> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Liver cirrhosis</i> | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature] M. Lawrence, MD</i> | | | | 29c. License number <i>97486</i> | | 29d. Date signed (Month, Day, Year) <i>November 18, 1999</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Suzanne M. Callamese, MD 4940 Eastern Avenue Baltimore, Maryland 21224</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>NOV 22 1999</i> | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36414

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Albert Benedict Matelis

2. Date of Death
Month Day Year
November 17 19993. Time of Death
2:15 PM

4a. Facility Name (If not institution, give street and number)

3607 Lilac Ave.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

215 12 9166

6. Sex

XX M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Oct. 6, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3607 Lilac Ave.

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Technical Engineer

16b. Kind of Business/Industry

Goddard Space Flight Center

17. Father's Name (First, Middle, Last)

Frank

Matelis

18. Mother's Name (First, Middle, Maiden Surname)

Marie

Zimitas

19a. Informant's Name/Relationship (Type, Print)

Albert J. Matelis / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3607 Lilac Avenue, Baltimore MD 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Stanislaus Cemetery 11/19/99

Date

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

Stephen D. Lohrmann

22. Name and Address of Facility

CAFA Stephen D. Lohrmann P.A.
8717 Green Pastures Dr., Baltimore, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Prostate Cancer

Approximate Interval Between Onset and Death

yrs.

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

B. Turaichia, MD

29c. License number

D36942

29d. Date signed (Month, Day, Year)

November 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. Turaichia, MD 1009 Frederick Rd., Baltimore, MD 21228

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

B. Turaichia

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Handwritten text at the bottom of the page, possibly a signature or date, followed by the printed text "JAN 1961".

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36415

AMENDED ITEM #5 PER FH G77812/15/99 AH

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HERSCHEL J. MASSEY, SR.

2. Date of Death
Month Day Year
NOVEMBER 22, 1999

3. Time of Death

7:10 AM

4a. Facility Name (If not institution, give street and number)

CATON MANOR NURSING HOME

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

241-16-5787
~~241-16-5868~~

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
3/24/1905

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

218 S. VINCENT STREET

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

SELF EMPLOYED

16b. Kind of Business/Industry

GROCER

17. Father's Name (First, Middle, Last)

JOHN MASSEY

18. Mother's Name (First, Middle, Maiden Surname)

FLORRIE KEEBLER

19a. Informant's Name/Relationship (Type, Print)

PAULINE H. MASSEY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3300 BENSON AVENUE, APT 101 BALTIMORE, MD 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

CEDAR HILL CEMETERY

Date

11.24.99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

KELLY GREGORY FINK

22. Name and Address of Facility

FINK FUNERAL HOME, PA

426 CRAIN HWY., SW, GLEN BURNIE, MD 21061

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)e. End-Stage Dementia
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Multiple cerebrovascular accidents
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anorexia

Atrial Fibrillation

History of Melanoma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
Investigation6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Shalini Tewari MD

29c. License number

D52671

29d. Date signed (Month, Day, Year)

November 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shalini Tewari MD / 11838 Greene Tree Road Suite 300 / Pikesville, MD 21208

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

Dennis B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36416

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY MASIMERZ

2. Date of Death

Month 11 Day 21 Year 99

3. Time of Death

11:25 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

217-20-3096

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
APRIL 5, 1923

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

PASADENA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1125 HOLMESPUEN DRIVE

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOME MAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

HARRY

L.

KING

18. Mother's Name (First, Middle, Maiden Surname)

CONSTANCE

GRENOVICH

19a. Informant's Name/Relationship (Type, Print)

PATRICIA D. PALEN- DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

961 BENNETT ROAD, ARNOLD, MARYLAND 21012

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PARK

Date

11/24/99

20c. Location - City or Town, State

GLEN BURNIE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME, PA.

1 SECOND AVE., S.W., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

fmo RESIDENT PHYSICIAN

29c. License number

P12381

29d. Date signed (Month, Day, Year)

11/21/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alex Chudnovsky, M.D. 23 South Green Baltimore, MD 21201

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36417

amended item 31 per dvr q777 11/22/99 ah

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Arleyne G. Miller | | | | 2. Date of Death Month Day Year October 25, 1999 | | 3. Time of Death 10:00 am | |
| 4a. Facility Name (If not institution, give street and number) 1413 Demarcie Way | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| 5. Social Security Number 215-30-9958 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 67 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct 31, 1931 | |
| 9. Birthplace (State or Foreign Country) MD | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 1413 Demarcie Way | | | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accounting Clerk | | 16b. Kind of Business/Industry Clothing | |
| 17. Father's Name (First, Middle, Last) Ralph Miller | | | | 18. Mother's Name (First, Middle, Maiden Surname) Irene O'Neil | | | |
| 19a. Informant's Name/Relationship (Type, Print) Michael Sisk, Sr/son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Eastship Road Baltimore, MD 21222 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Data | | 20c. Location - City or Town, State | | | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | |

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician
/Medical
Examiner

| | | | | | |
|--|--|---|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. END STAGE RENAL DISEASE Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE Due to (or as a consequence of): c. DIABETES Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier Shirley A. Mach, MD | | | |
| | | 29c. License number DS0233 | | 29d. Date signed (Month, Day, Year) 11/15/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1000 CATHEDRAL STREET, BALTIMORE, MD 21201 | | | | | |
| 31. Date filed (Month, Day, Year) 11/15/99 NOV 22 1999 | | 32. Registrar's Signature James B. Sparks | | | |

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760, BALTIMORE, MD 21201

NOV 15 1999

Handwritten signature and date: 1928

99 36418

ORIGINAL

[Faint handwritten signature]

NOV 2 1952

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36419

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FREDERICK D. MILLER JR.

2. Date of Death

November 18, 1999

3. Time of Death

6:51 PM

4a. Facility Name (If not institution, give street and number)

FALLSTON GENERAL HOSPITAL

4b. City, Town, or Location of Death

FALLSTON

4c. County of Death

HARFORD

Funeral
Director

5. Social Security Number

216-28-0709

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT 1, 1932

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

HARFORD

10c. City, Town or Location

FALLSTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

2301 EDINBURG DRIVE

10f. Zip Code

21047

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: KOREAN WAR.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12thCollege (1-4 or 5+)
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SUPERVISOR

16b. Kind of Business/Industry

GAS COMPANY.

17. Father's Name (First, Middle, Last)

FREDERICK D. MILLER SR.

18. Mother's Name (First, Middle, Maiden Surname)

EDITH HALL

19a. Informant's Name/Relationship (Type, Print)

PEGGY N. MILLER (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2301 EDINBURG DR. FALLSTON MD, 21047

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. PAUL'S LUTHERAN Cem.

Date

11/22/99

20c. Location - City or Town, State

KINGSVILLE, MD

21. Signature of Funeral Service Licensee

Paul M. Stella

22. Name and Address of Facility

HARTLEY MILLER Funeral Home CHD.
7527 HARFORD RD. BALTO MD 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

METASTATIC CANCER

e. Due to (or as a consequence of):

CANCER PROSTATE

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul M. Stella M.D.

29c. License number

OCME

29d. Date signed (Month, Day, Year)

NOV 18 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GRABER, MD 218 EIGHTH AVE BELAIR MD 21014

State
Registrar

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

Barbara B. Sparks

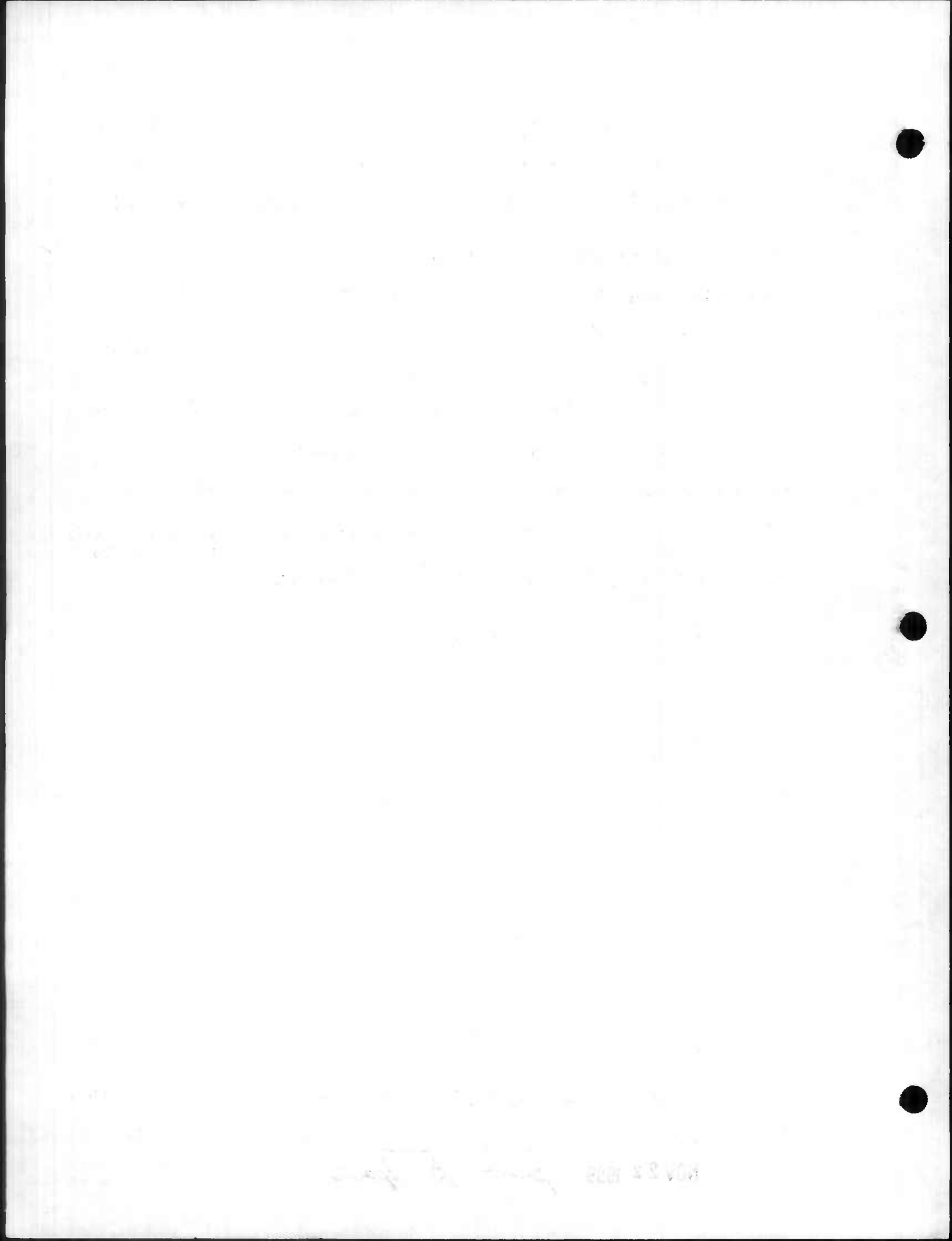
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36420

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Irene Orr Namuth | | | | 2. Date of Death Month Day Year November 19, 1999 | | 3. Time of Death 2:00 AM | |
| | 4a. Facility Name (If not institution, give street and number) 8059 Woodholm Circle | | | | 4b. City, Town, or Location of Death Pasadena | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 449-20-8000 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 10, 1917 | |
| | 9. Birthplace (State or Foreign Country) Texas | | 10a. State Md. | | 10b. County Anne Arundel | | 10c. City, Town or Location Pasadena | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 8059 Woodholm Circle | | 10f. Zip Code 21122 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical US Government | | 16b. Kind of Business/Industry Finance Dept. Ft. Meade | | | |
| | 17. Father's Name (First, Middle, Last) Tom Rudd | | | | 18. Mother's Name (First, Middle, Maiden Surname) Cora Hollinsworth | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Shirley Brabbin (Aunt) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 Robin Lane, Garlin, Texas 75041 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc. | | 20c. Location - City or Town, State Baltimore, Maryland | | 20d. Date 11/20 | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, 21122 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Idiopathic Pulmonary Fibrosis</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 20 years | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier | | | | 29c. License number D20094 | | 29d. Date signed (Month, Day, Year) 11/19/99 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elliott Garbity MD, 7845 Oakwood Rd, Glen Burnie, MD, 21061 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 22 1999 | | | | 32. Registrar's Signature | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten text, possibly a signature or date, appearing upside down.

1900 S. S. VOLT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36421

| | | | | | | | | |
|--|--|---|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Pearl Palmer | | | | 2. Date of Death Month Nov. Day 17 , Year 99 | | 3. Time of Death 9:00pm | |
| | 4a. Facility Name (If not institution, give street and number) Irvington Knolls Nursing Home | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NA | |
| Funeral Director | 5. Social Security Number 212-20-0489 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 84 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 03-08-15 | 9. Birthplace (State or Foreign Country) NC |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 22 S. Athol Avenue | | | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th Grade College (1-4or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic | | | 16b. Kind of Business/Industry other people homes | |
| 17. Father's Name (First, Middle, Last) Dennis Waters | | | | 18. Mother's Name (First, Middle, Maiden Surname) Carrie Pope Waters | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Justine Waters | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19131 5340 Lansdowne Avenue Philadelphia, PA | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Kings Mem. Pk. Cem. | | Date 11-24-99 | | 20c. Location - City or Town, State Randallstown, MD | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) a. Brain stem infarct | | | | | | | | 6 month |
| Due to (or as a consequence of): | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. cerebrovascular accident, multiple | | | | | | | | 1 Yr |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number 031P65 | | 29d. Date signed (Month, Day, Year) 11-19-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael D. King Rm 206 821 N Antaw street Balt md | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Handwritten text at the bottom of the page, possibly a signature or date, followed by the printed text "NOV 19 1988".

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36422

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD JAMES PHILLIPS

2. Date of Death

Month Day Year
NOV 17, 19993. Time of Death
1:58 PM

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

SACOUNTY

Funeral
Director

5. Social Security Number

270-26-3336

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 20, 1930

9. Birthplace (State or Foreign Country)

OHIO

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

200 JUNIPER DRIVE

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No 1952-

If Yes, Give Year or Dates: 1956

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

ELECTRICAL ENGINEER

16b. Kind of Business/Industry

WESTINGHOUSE

17. Father's Name (First, Middle, Last)

MARTIN

18. Mother's Name (First, Middle, Maiden Surname)

MARIE

ATKINSON

19a. Informant's Name/Relationship (Type, Print)

DOLORES PHILLIPS (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

200 JUNIPER DRIVE, GLEN BURNIE, MARYLAND 21060

20a. Method of Disposition

1 ☐ Burial ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATION CENTER, LLC

Date

11/19/99

20c. Location - City or Town, State

STEVENSVILLE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME, P.A.,

1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. "Sudden Cardiac Death"

Due to (or as a consequence of):

b. Malignant Ventricular Arrhythmia

Due to (or as a consequence of):

c. Dilated Cardiomyopathy

Due to (or as a consequence of):

d. Ischemic Heart Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D43623

29d. Date signed (Month, Day, Year)

11/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Erik L. Russell, M.D. 795 Aquahart Road, Suite 203, Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

State Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner


Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.


Phillips, Richard
Baltimore, Maryland 21215-0020

VOID

CERTIFICATE 

99-36423

SEE

CERTIFICATE 

99-37251

AdP
2/16/2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36424

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

LUCILLE

2. Date of Death

Month Day Year
NOVEMBER 18 1999

3. Time of Death

10:33AM

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

023-22-9627

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

8. Date of Birth (Month, Day, Year)

Dec. 20, 1929

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7730 Fairgreen Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Alfred Roy

18. Mother's Name (First, Middle, Maiden Surname)

Delia Renaud

19a. Informant's Name/Relationship (Type, Print)

Nancy A. White (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7227 Stratton Way Baltimore, Maryland 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Ht. of Jesus Cem.

Date

11/22/99

20c. Location - City or Town, State

Dundalk, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CHRONIC OBSTRUCTIVE PULMONARY DISEASE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Smoking
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0036870

29d. Date signed (Month, Day, Year)

NOVEMBER 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VARTANIAN, R. JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE, MARYLAND 21224

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

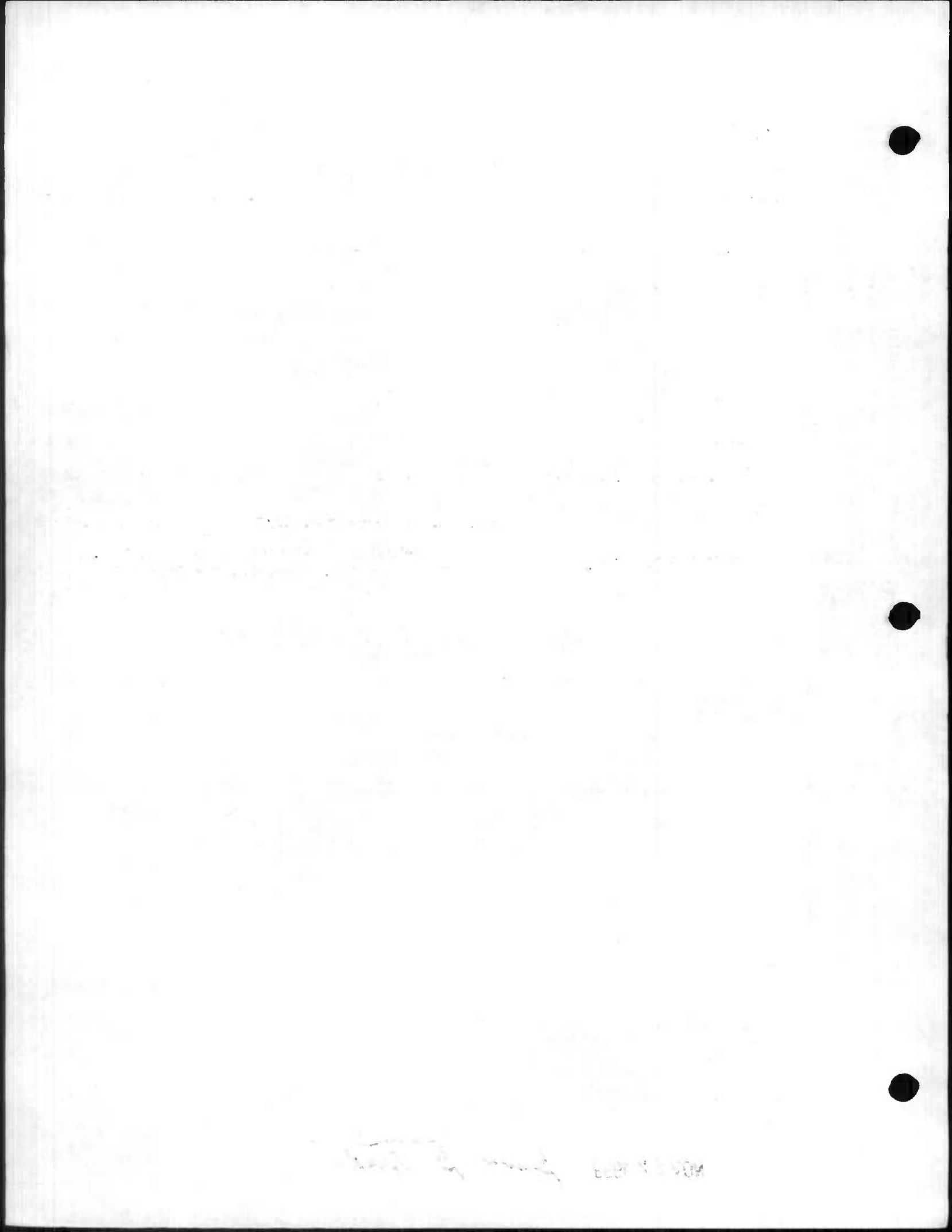
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36425

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond Melvin Royston

2. Date of Death

Nov 18 1999

3. Time of Death

08:35AM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219 01 8373

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 4, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13801 York Rd.

Unit C18

10f. Zip Code

21030

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or

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13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

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14. Race - American Indian, Black, White, etc.

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15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

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16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Self Employed

Self Employed

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36426

| | | | | | | | | |
|---|--|--|---|--|--|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JACK RAINY | | | | 2. Date of Death Month Nov Day 9th Year 99 | | 3. Time of Death 1:50 am | |
| | 4a. Facility Name (If not institution, give street and number) East Point Nursing Home | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 213-09-2269 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 91 Yrs. | | 8. Date of Birth (Month, Day, Year) March 21, 1908 | |
| | 10e. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 1046 North Point Road | | | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Brakeman | | 16b. Kind of Business/Industry Railroad | | |
| 17. Father's Name (First, Middle, Last) Tom Andrew Rainey | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rushie Morgan | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Peggy Gregory/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Northship Road Baltimore, MD 21222 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure End stage Dementia | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner | | 29f. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | |
| 29b. Signature and title of certifier [Signature] | | 29c. License number D43725 | | | | 29d. Date signed (Month, Day, Year) 11/17/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOOD 201-109 Back River Neck Rd Baltimore 21221 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature [Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36427

| | | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|--|--|--|---|---|----|------------------------------------|---------------|----|--------------------------------|----------------|----|--|--|----|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JENNIE E SHEAR | | | | 2. Date of Death Month: NOV Day: 16 Year: 1999 | | 3. Time of Death 8:05PM | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL | | | | 4b. City, Town, or Location of Death SILVER SPRING | | 4c. County of Death MONTGOMERY | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 236-36-2190 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 94 Yrs. | If Under 1 Year Months: Days: | If Under 24 Hrs. Hours: Min. | 8. Date of Birth (Month, Day, Year) MAY 31, 1905 | 9. Birthplace (State or Foreign Country) RUSSIA | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | |
| 10a. State MD | | 10b. County MONTGOMERY | | 10c. City, Town or Location ROCKVILLE | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | |
| 10e. Street and Number 6111 MONTROSE RD. | | | | 10f. Zip Code 20852 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER | | 16b. Kind of Business/Industry RETAIL | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) HARRY | | | | 18. Mother's Name (First, Middle, Maiden Surname) DORA | | PATS | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MRS. RUTH LEVIN (DAU.) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1017 DOWNS DR. SILVER SPRING, MD 20904 | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MIKRO KODESH-BETH ISRAEL | | Date 11/18/99 | | 20c. Location - City or Town, State BALTIMORE, MD | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>ACUTE MYOCARDIAL INFARCTION</td> <td>3 DAYS</td> </tr> <tr> <td>b.</td> <td>CORONARY ARTERY DISEASE</td> <td>5 YEARS</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | ACUTE MYOCARDIAL INFARCTION | 3 DAYS | b. | CORONARY ARTERY DISEASE | 5 YEARS | c. | | | d. | | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | ACUTE MYOCARDIAL INFARCTION | 3 DAYS | | | | | | | | | | | | | | | | | |
| | b. | CORONARY ARTERY DISEASE | 5 YEARS | | | | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | | | | | | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number 029293 | | 29d. Date signed (Month, Day, Year) 11/17/99 | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10313 GEORGIA AVE SILVER SPRING, MD 20902 DR. MICHAEL LINCOLN | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature  | | | | | | | | | | | | | | | | | | |

Handwritten signature and text: *Handwritten signature* ERD. DE. VON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36428

Amended Item#10f perFHG777 11/22/99 FW

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

ALICE

M.

STRINGER

2. Date of Death
Month

Day

Year

NOVEMBER 16, 1999

3:45 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

111-05-6914

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

JAN. 10, 1912

9. Birthplace (State or Foreign Country)

MA

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8800 WALTHER BLVD.

10f. Zip Code

21236 ~~21234~~

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

PIANIST

16b. Kind of Business/Industry

MUSIC

17. Father's Name (First, Middle, Last)

ZELIG

NEVINS

18. Mother's Name (First, Middle, Maiden Surname)

FANNIE

(UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

EDWARD STRINGER / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5711 N. CHARLES STREET - BALTIMORE, MD 21210

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HAR SINAI CEMETERY

Data

20c. Location - City or Town, State

11/17/99 OWINGS MILLS, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

ANEMIA

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 37254

29d. Date signed (Month, Day, Year)

11/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROON-P. LIM, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

B. Sports

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Stringer, Alice
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36429

AMENDED ITEM #9 PER FH G777 11/22/99 AH

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Bruce Sullivan

2. Date of Death

Month

Day

Year

11

07

99

3. Time of Death

2325

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Maryland Transition Ctr.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

216 74 1546

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct 31, 1957

9. Birthplace (State or Foreign Country)

10/31/57 MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

954 Forest Street

10f. Zip Code

21202

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Robert Sullivan

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Boston

19a. Informant's Name/Relationship (Type, Print)

Brian Sullivan/brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3120 Keswick Rd Baltimore, MD 21211

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, Md 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. AIDS
Due to (or as a consequence of):b. Histoplasmosis
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Prison Infirmary

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

N/A

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Patricia Wright M.D. D41235

29c. License number

MD -

29d. Date signed (Month, Day, Year)

11/8/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Patricia Wright, M.D.

954 Forrest St. Baltimore Md. 21202

31. Date (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36430**
Certificate of Death

AMEND#8 PER MD. G779 1-31-2000 J.A.
 AMEND#9 PER K.B. G777 11-20-99 J.A.

Reg. No.

**Physician
/Medical
Examiner**

**Funeral
Director**

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Nicholas Michael Shawver | | | | 2. Date of Death Month Day Year October 24 1999 | | 3. Time of Death 8:53 pm | |
| 4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | |
| 5. Social Security Number NONE | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) Yrs. Months Days 0 20 | | 8. Date of Birth (Month, Day, Year) 10-24-99 | |
| 9. Birthplace (State or Foreign Country) MD. | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Havre de Grace | | 10c. City, Town or Location 11 Heron Court | | 10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 21078 | | | | 10f. Zip Code USA | | 10g. Citizen of What Country? | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) None None | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None | | 16b. Kind of Business/Industry None | |
| 17. Father's Name (First, Middle, Last) Ronald Shawver | | | | 18. Mother's Name (First, Middle, Maiden Surname) Joy L. Harris | | | |
| 19a. Informant's Name/Relationship (Type, Print) Nikki Chilcoat (STAFF) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) G.B.M.C., 6701 N. CHARLES, TOWSON, MD 21204 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GREEN MT. CREMATORY | | 20c. Location - City or Town, State 10-30 BALTO, MD. 21202 | | | |
| 21. Signature of Funeral Service Licensee R. J. Lutz | | | | 22. Name and Address of Facility H.W. JENKINS & SONS CO. 4905 YORK RD. BALTIMORE, MD., 21212 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Extreme prematurity Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death 20 min | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28e. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier J. J. Lawrence, M.D. | | | | | |
| | | 29c. License number D0051676 | | 29d. Date signed (Month, Day, Year) 10/28/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GBMC 6701 N. Charles Street Towson Maryland 21204 | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature [Signature] | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Handwritten text, mostly illegible due to fading. Some words like "The" and "and" are visible.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36431

AMENDED ITEMS 20a- 22 PER FH G777 11/23/99 AH

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) CLARA THOMPSON
2. Date of Death Month Day Year Nov 15 1999
3. Time of Death 1250 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number) Eastpoint Nursing & Rehab
4b. City, Town, or Location of Death Baltimore
4c. County of Death N/A

5. Social Security Number 218-28-5217
6. Sex ☐ M ☒ F
7. Age (In yrs. last birthday) 67 Yrs.
8. Date of Birth (Month, Day, Year) June 9, 1932
9. Birthplace (State or Foreign Country) MD

Usual Residence of Decedent

10a. State MD
10b. County N/A
10c. City, Town or Location Baltimore
10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 1832 Ashland Ave
10f. Zip Code 21215
10g. Citizen of What Country? USA

11. Marital Status
☐ Never Married ☐ Married
☒ Widowed ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:
14. Race - American Indian, Black, White, etc.
Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4or 5+) 4
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Teacher
16b. Kind of Business/Industry
Education

17. Father's Name (First, Middle, Last) John Thompson
18. Mother's Name (First, Middle, Maiden Surname) Clara Lancaster

19a. Informant's Name/Relationship (Type, Print) Yvonne Stenhouse/guardian
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown

20a. Method of Disposition
☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☒ Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place) NEW CATHEDRAL CEMETERY
Data 11-19-99
20c. Location - City or Town, State BALTIMORE, MD

21. Signature of Funeral Service Licensee
Francis X. George
22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 MARCH FUNERAL HOME
1101 E NORTH AVENUE

23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. T cell Lymphoma
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Approximate Interval Between Onset and Death 1 Year
23b. Did tobacco use contribute to the cause of death?
☐ Yes ☐ No ☐ Probably ☒ Unknown
24a. Was an autopsy performed?
☐ Yes ☒ No
24b. Were autopsy findings available prior to completion of cause of death?
☐ Yes ☒ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Schizophrenia, DM
25. Was case referred to medical examiner?
☐ Yes ☒ No
26. Place of Death (Check only one)
Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA
Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)
27. Manner of Death
☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work?
☐ Yes ☒ No
28d. Describe how injury occurred
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
Matthew K. McNabney
29c. License number
D45757
29d. Date signed (Month, Day, Year)
Nov 15, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MATTHEW McNABNEY 5505 HOPKINS Bayview Circle BALTIMORE 21229

State
Registrar

31. Date filed (Month, Day, Year) NOV 22 1999
32. Registrar's Signature
G. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

#23 PART I, 27 28A-F PER MEO G780 2-8-2000 WR

Certificate of Death

Reg. No.

99 36432

| | | | | | | | | | | | | | | |
|--|---|------------------------|--|--|---|---|--------------------------------|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Unknown 99-170 | | | | 2. Date of Death Month Day Year August 03, 1999 | | | | 3. Time of Death 9:50 A.M. | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Baltimore Harbor, 800 East Pratt Street | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | | | | | |
| Funeral Director | 5. Social Security Number unknown | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) unknown Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) unknown | | 9. Birthplace (State or Foreign Country) unknown | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| 10a. State unknown | | 10b. County unknown | | 10c. City, Town or Location unknown | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No unknown | | | | | | |
| 10e. Street and Number unknown | | | | 10f. Zip Code unknown | | | | 10g. Citizen of What Country? unknown | | | | | | |
| 11. Marital Status unknown 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: unknown | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (14 or 5+) unknown | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown | | | | 16b. Kind of Business/Industry unknown | | | | | | |
| 17. Father's Name (First, Middle, Last) unknown | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) unknown | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) O.C.M.E. | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201 | | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Data | | | | 20c. Location - City or Town, State | | | | | | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DROWNING Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene | | | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) 8-3-1999 | | 28b. Time of Injury 9:32 A M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred SUBJECT DROWNED | | | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HARBOR | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 800 E. PRATT ST. BALTIMORE, MD. | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier Theodore M. King | | | | | | 29c. License number O.C.M.E. | | | 29d. Date signed (Month, Day, Year) August 03, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

99-6811-510

DDG

EDWARD L. WILDY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F

PER MEO G77711-29-99 WR.

Reg. No.

99 36433

| | | | | | | | | | | | | | | | |
|---|---|--|--|---|---|-------------------------------------|--------------------------------|--|--------------------------------|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edward Leon Wildy | | | | 2. Date of Death Month Day Year NOVEMBER 14, 1999 | | | | 3. Time of Death 1242 PM | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 613 GIBSON ROAD | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death NA | | | | | | |
| Funeral Director | 5. Social Security Number 214-62-1635 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 44 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) 02-07-55 | | 9. Birthplace (State or Foreign Country) MD | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| 10e. State MD | | 10f. County NA | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 10e. Street and Number 613 Gibson Road | | | | 10f. Zip Code 21229 | | | | 10g. Citizen of What Country? USA | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mason Plaster | | | | 16b. Kind of Business/Industry Rosewood State Hosp. | | | | | | | |
| 17. Father's Name (First, Middle, Last) Charles E. Wildy | | | | 18. Mother's Name (First, Middle, Maiden Summa) Mary Burrell | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary Wildy | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2407 Roslyn Avenue Baltimore, Maryland 21216 | | | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Kings Mem. Pk. Cem. | | | | Data 11-20-99 | | 20c. Location - City or Town, State Randallstown, MD | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC AND COCAINE INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| | | | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) Found: 11-14-99 | | 28b. Time of Injury Found: 12:20 | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred UNKNOWN | | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND: RESIDENCE | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 613 GIBSON ROAD BALTIMORE, MARYLAND | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number O.C.M.E. | | | | 29d. Date signed (Month, Day, Year) NOVEMBER 15, 1999 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARRISON A. KOREN 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

NOV 2 1955

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36436

| | | | | | | | | |
|--|---|---|---|---|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DAVID WILLIS | | | | 2. Date of Death Month NOVEMBER Day 17 Year 1999 | | 3. Time of Death 1:45 pm | |
| | 4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview 4940 Eastern Ave | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 214-01-2432 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 91 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 3, 1908 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore City | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 1706 Charlotte Avenue | | | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Years College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Foreman | | | 16b. Kind of Business/Industry Steel Industry | |
| 17. Father's Name (First, Middle, Last) Frank Willis | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Anna Glossner | | | |
| 19a. Informant's Name/Relationship (Type, Print) Carolyn G. Willis (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1706 Charlotte Ave. Baltimore, Maryland 21224 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery | | | 20c. Location - City or Town, State Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary Artery Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Renal insufficiency | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) NOVEMBER 17, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Craig Smith Tower 10 Johns Hopkins Hospital 600 North Wolfe Street Baltimore, MD 21287 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36435

| | | | | | | | | |
|--|---|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) THEODA L. WEINER | | | | 2. Date of Death Month Day Year NOV 16th 1999 | | 3. Time of Death 04:45 AM | |
| | 4a. Facility Name (If not institution, give street and number) LEVINDALE NURSING HOME | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 258-28-2487 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 93 Yrs. | | 8. Date of Birth (Month, Day, Year) OCT. 28, 1906 | |
| | 9. Birthplace (State or Foreign Country) GA | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 2801 TANEY ROAD | | 10f. Zip Code 21209 | | |
| 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc. WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSE | | 16b. Kind of Business/Industry MEDICINE | | |
| 17. Father's Name (First, Middle, Last) TOM WILLIAM LEWIS | | 18. Mother's Name (First, Middle, Maiden Surname) LAVONIA OGLESBY | | 19a. Informant's Name/Relationship (Type, Print) SHELDON DOBRES / NEPHEW | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 CALYPSO COURT - BALTIMORE, MD 21209 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BETH JACOB ANSHE VESHEAR | | 20c. Date 11/17/99 | | 20d. Location - City or Town, State ROSEDALE, MD | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): DEHYDRATION Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2 weeks | | Approximate Interval Between Onset and Death 7 days | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) NOV 16 1999 | | |
| 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>[Signature]</i> M.D. | | 29c. License number 00054739 | | |
| 29d. Date signed (Month, Day, Year) November 16th 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE GERIATRIC CENTER, 2384 W. BELVEDERE, BALTIMORE MARYLAND 21215 | | 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | |

NOV 15 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36436

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Norman H. Williams, Jr.

2. Date of Death

Month

Day

Year

NOV 5, 1999

3. Time of Death

7:44AM

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GIEN BURNIE

4c. County of Death

AA COUNTY

Funeral
Director

5. Social Security Number

085-46-0918

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

44

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

12/18/54

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1525 Fairmont Ave.

10f. Zip Code

21231

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Educational

17. Father's Name (First, Middle, Last)

Norman Williams, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Mitchell Williams

19a. Informant's Name/Relationship (Type, Print)

Mildred Williams (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

935 Philpotts Rd. Norfolk, Va. 23513

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Tidewater Crematorium

Date

11/10/99

20c. Location - City or Town, State

Norfolk, Va.

21. Signature of Funeral Service Licensee

Samuel Savage

22. Name and Address of Facility

Savage Funeral Home

New Church, Virginia 23415

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. OBESITY

Due to (or as a consequence of):

c. HYPERTENSION

Due to (or as a consequence of):

d. 1 BACK CERVICAL SPONDYLOLISTHESIS

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

[Signature]

29c. License number

025782

29d. Date signed (Month, Day, Year)

11/05/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

STEVEN L. BOBBI MD 7575 CLITONIA HIGHWAY GLEN BURNIE MD, 21061

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

[Signature]

Williams NORMAN
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Handwritten text at the bottom of the page, possibly a signature or date, and a date stamp.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36437

| | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|---|--|--|--|--|--|---|----|-----------|--|----|--|---------|----|--|---------|----|----------------------------------|---------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Dorothy E. Wienhold | | | | 2. Date of Death Month Day Year Nov. 19, 1999 | | 3. Time of Death 1:56 PM | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not Institution, give street and number) GENESIS ELDER CARE | | | | 4b. City, Town, or Location of Death SEVERNA PARK | | 4c. County of Death ANNE ARUNDEL | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 216-14-3843 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) MARCH 5, 1923 | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | 10a. State MARYLAND | | 10b. County BALTIMORE | | 10c. City, Town or Location BROOKLYN PARK | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 301 GROVE PARK ROAD | | 10f. Zip Code 21225 | | 10g. Citizen of What Country? U.S.A. | | | | | | | | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALESPERSON | | 16b. Kind of Business/Industry DEPARTMENT STORE | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) RUEBEN DAY | | | | 18. Mother's Name (First, Middle, Maiden Surname) LILLIAN McCAULEY | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) CURTIS M. WIENHOLD- SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 RUSTIC RIDGE, SEVERNA PARK, MD 21146 | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK | | 20c. Location - City or Town, State 11/22/99 GLEN BURNIE, MD | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, PA. 1 SECOND AVENUE, S.W., GLEN BURNIE, MD 21061 | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Pneumonia</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of): Congestive Heart failure</td> <td>4 weeks</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of): Malnutrition</td> <td>4 weeks</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td>2 weeks</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. | Pneumonia | Approximate Interval Between Onset and Death | b. | Due to (or as a consequence of): Congestive Heart failure | 4 weeks | c. | Due to (or as a consequence of): Malnutrition | 4 weeks | d. | Due to (or as a consequence of): | 2 weeks |
| | Immediate Cause (Final disease or condition resulting in death) | a. | Pneumonia | Approximate Interval Between Onset and Death | | | | | | | | | | | | | | | | | |
| b. | | Due to (or as a consequence of): Congestive Heart failure | 4 weeks | | | | | | | | | | | | | | | | | | |
| c. | | Due to (or as a consequence of): Malnutrition | 4 weeks | | | | | | | | | | | | | | | | | | |
| d. | | Due to (or as a consequence of): | 2 weeks | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier Don. Lewis | | | | 29c. License number D40519 | | 29d. Date signed (Month, Day, Year) NOVEMBER 22, 1999 | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. MIRZA NUSAIREE 7845 OAKWOOD ROAD #200, GLEN BURNIE, MD 21061 | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature Benjamin B. Sparks | | | | | | | | | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36438

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SHIRLEY

WALKER

2. Date of Death

Month

Day

Year

November 18 1999

3. Time of Death

9:07 A.M.

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

191-38-0242

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 20, 1946

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

594 NOLBERRY DRIVE

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates: 1964-1968

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

REAL ESTATE AGENT

16b. Kind of Business/Industry

REAL ESTATE

17. Father's Name (First, Middle, Last)

OSCAR

EDWARDS

18. Mother's Name (First, Middle, Maiden Surname)

ROSIE

LEE

BAILEY

19a. Informant's Name/Relationship (Type, Print)

WARREN WALKER, SR. - HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

594 NOLBERRY DRIVE, GLEN BURNIE, MD 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PARK

Date

11/23/99

20c. Location - City or Town, State

GLEN BURNIE, MD

21. Signature of Funeral Service Licensee

Michael C. Jaffer

22. Name and Address of Facility

SINGLETON FUNERAL HOME, PA.

1 SECOND AVE., S.W., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC UTERINE CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. [Signature]

29c. License number

D43977

29d. Date signed (Month, Day, Year)

November 18 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carmen G. [Signature] 301 Hospital Dr., Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

[Signature]

State
RegistrarWalker, Shirley
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36439

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PAUL

ZIPPERT

2. Date of Death
Month Day Year
November 15 19993. Time of Death
23:49

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

217-16-3999

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

SEP. 9, 1920

9. Birthplace (State or Foreign Country)

GERMANY

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

REISTERSTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

564 KENNINGTON ROAD

10f. Zip Code

21136

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

BRACEMAKER

16b. Kind of Business/Industry

MEDICAL EQUIPMENT

17. Father's Name (First, Middle, Last)

MAX

ZIPPERT

18. Mother's Name (First, Middle, Maiden Surname)

HELENE

KAUFMAN

19a. Informant's Name/Relationship (Type, Print)

BERTL ZIPPERT / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

564 KENNINGTON ROAD - REISTERSTOWN, MD 21136

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHEVRA AHAVAS CHESD

Date

11/18/99

20c. Location - City or Town, State

RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee

Scott M. Cutler

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 2120823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. GI bleeding

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

David J. Spinabene

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

November 15, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Sinai Hospital 2401 W. Belvedere Ave Baltimore, MD

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

James B. Spaul

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

10

Known as Paul Zippert

Handwritten signature

DEPT S S VON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36440

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EARL DAVID ANDERSON

2. Date of Death

Month Day Year

OCTOBER 29, 1999

3. Time of Death

3:25 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

WILLIAMSPORT RETIREMENT VILLAGE

4b. City, Town, or Location of Death

WILLIAMSPORT

4c. County of Death

WASHINGTON

5. Social Security Number

215-09-7350

6. Sex

1X M 2 F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sep. 1, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 Y 2 X No

10e. Street and Number

17616 Virginia Ave.

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No

If Yes, Give

Year or Dates: 1942-

1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 X No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Illustrator

16b. Kind of Business/Industry

Aircraft Manufacture

17. Father's Name (First, Middle, Last)

David Charles

Anderson

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Leona

Cole

19a. Informant's Name/Relationship (Type, Print)

RAndall E. Anderson (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17616 Virginia Ave. Hagerstown, MD 21740

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Riverview Cemetery Nov. 1, 1999

Date

20c. Location - City or Town, State

Williamsport, MD 21795

21. Signature of Funeral Home Director

22. Name and Address of Facility

OSBORNE FUNERAL HOME

P.O. Box # 348 Williamsport, MD 21795

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. CONGESTIVE HEART FAILURE, END-STAGE

MONTHS

Due to (or as a consequence of):

b. ISCHEMIC CARDIOMYOPATHY

YEARS

Due to (or as a consequence of):

c. HYPERTENSIVE HEART DISEASE

YEARS

Due to (or as a consequence of):

d.

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LYMPHOCYTIC LEUKEMIA

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy
performed?

1 Yes 2 X No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2 No

25. Was case referred to medical
examiner?

1 Yes 2 X No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 X Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending

investigation

6 Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury et

Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)

1 X

2

Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

29e. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29f. Date filed (Month, Day, Year)

29g. Registrar's Signature

29h. Date filed (Month, Day, Year)

29i. Registrar's Signature

29j. Date filed (Month, Day, Year)

29k. Registrar's Signature

29l. Date filed (Month, Day, Year)

29m. Registrar's Signature

29n. Date filed (Month, Day, Year)

29o. Registrar's Signature

29p. Date filed (Month, Day, Year)

29q. Registrar's Signature

29r. Date filed (Month, Day, Year)

29s. Registrar's Signature

29t. Date filed (Month, Day, Year)

29u. Registrar's Signature

29v. Date filed (Month, Day, Year)

29w. Registrar's Signature

29x. Date filed (Month, Day, Year)

29y. Registrar's Signature

29z. Date filed (Month, Day, Year)

29aa. Registrar's Signature

29ab. Date filed (Month, Day, Year)

29ac. Registrar's Signature

29ad. Date filed (Month, Day, Year)

29ae. Registrar's Signature

29af. Date filed (Month, Day, Year)

29ag. Registrar's Signature

29ah. Date filed (Month, Day, Year)

29ai. Registrar's Signature

29aj. Date filed (Month, Day, Year)

29ak. Registrar's Signature

29al. Date filed (Month, Day, Year)

29am. Registrar's Signature

29an. Date filed (Month, Day, Year)

29ao. Registrar's Signature

29ap. Date filed (Month, Day, Year)

29aq. Registrar's Signature

29ar. Date filed (Month, Day, Year)

29as. Registrar's Signature

29at. Date filed (Month, Day, Year)

29au. Registrar's Signature

29av. Date filed (Month, Day, Year)

29aw. Registrar's Signature

29ax. Date filed (Month, Day, Year)

29ay. Registrar's Signature

29az. Date filed (Month, Day, Year)

29ba. Registrar's Signature

29bb. Date filed (Month, Day, Year)

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29bh. Date filed (Month, Day, Year)

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29bj. Date filed (Month, Day, Year)

29bk. Registrar's Signature

29bl. Date filed (Month, Day, Year)

29bm. Registrar's Signature

29bn. Date filed (Month, Day, Year)

29bo. Registrar's Signature

29bp. Date filed (Month, Day, Year)

29bq. Registrar's Signature

29br. Date filed (Month, Day, Year)

29bs. Registrar's Signature

29bt. Date filed (Month, Day, Year)

29bu. Registrar's Signature

29bv. Date filed (Month, Day, Year)

29bw. Registrar's Signature

29bx. Date filed (Month, Day, Year)

29by. Registrar's Signature

29bz. Date filed (Month, Day, Year)

29ca. Registrar's Signature

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29cc. Registrar's Signature

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29cp. Date filed (Month, Day, Year)

29cq. Registrar's Signature

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29cu. Registrar's Signature

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29cw. Registrar's Signature

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29cy. Registrar's Signature

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29da. Registrar's Signature

29db. Date filed (Month, Day, Year)

29dc. Registrar's Signature

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29df. Date filed (Month, Day, Year)

29dg. Registrar's Signature

29dh. Date filed (Month, Day, Year)

29di. Registrar's Signature

29dj. Date filed (Month, Day, Year)

29dk. Registrar's Signature

29dl. Date filed (Month, Day, Year)

29dm. Registrar's Signature

29dn. Date filed (Month, Day, Year)

29do. Registrar's Signature

29dp. Date filed (Month, Day, Year)

29dq. Registrar's Signature

29dr. Date filed (Month, Day, Year)

29ds. Registrar's Signature

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29ex. Date filed (Month, Day, Year)

29ey. Registrar's Signature

29ez. Date filed (Month, Day, Year)

29fa. Registrar's Signature

29fb. Date filed (Month, Day, Year)

29fc. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36441

Certificate of Death

Reg. No.

| | | | | | |
|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Leona Ruth Ashby | | 2. Date of Death Month October Day 17 Year 1999 | | 3. Time of Death 9:09 pm |
| | 4a. Facility Name (If not institution, give street and number) 11044 Harding Road | | 4b. City, Town, or Location of Death Laurel | | 4c. County of Death Howard |
| Funeral Director | 5. Social Security Number 214-28-9377 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 67 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) Jan 01, 1932 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | 10b. County Howard | 10c. City, Town or Location Laurel | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 11044 Harding Road | | 10f. Zip Code 20723 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | |
| 17. Father's Name (First, Middle, Last) Harold T. Coon | | | 18. Mother's Name (First, Middle, Maiden Surname) Celeste Elizabeth Chalmers | | |
| 19a. Informant's Name/Relationship (Type, Print) Joseph T. Ashby /spouse | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11044 Harding Road, Laurel, Maryland 20723 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Emmanuel Cemetery | | 20c. Location - City or Town, State 10/20/99 Scaggsville, Maryland | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. Small cell lung cancer - metastatic Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | Approximate Interval Between Onset and Death 2 wks. 13 months |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic anemia Radiation to chest and spine Anorexia / Cachexia | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | 29c. License number D30573 | 29d. Date signed (Month, Day, Year) 10-18-99 |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Jon K. Munford, 11065 Little Patuxent Parkway, Columbia MD. | | | | | |
| 31. Date filed (Month, Day, Year) OCT 19 1999 | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36442

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) CARL RUDELL ANGLEBERGER | | 2. Date of Death Month Day Year October 24, 1999 | | 3. Time of Death 2:23 P.M. | |
| 4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital | | | 4b. City, Town, or Location of Death Frederick | | 4c. County of Death Frederick |
| 5. Social Security Number 220-16-0794 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 7, 1923 |
| 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | 10b. County Frederick | | 10c. City, Town or Location Keymar |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 11713-A, Woodsboro Pike | | 10f. Zip Code 21757 | |
| 10g. Citizen of What Country? United States | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dairy Farmer | | 16b. Kind of Business/Industry Own Dairy Farm | | 17. Father's Name (First, Middle, Last) Carl W. Angleberger | |
| 18. Mother's Name (First, Middle, Maiden Surname) Virgie Ann Dodd | | 19a. Informant's Name/Relationship (Type, Print) Marian Nash Angleberger / wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11713-A, Woodsboro Pike/ Keymar, MD 21757 | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery | | 20c. Location - City or Town, State 10-27-99 Frederick, Maryland | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Gunshot wound to the head Due to (or as a consequence of): Sepsis Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | |
| 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | |
| 28a. Date of Injury (Month, Day, Year) Oct. 21, 99 | | 28b. Time of Injury 7:20 A M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred Self inflicted gun shot | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) 11713-A, Woodsboro Pike | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number D 35164 | |
| 29d. Date signed (Month, Day, Year) October 26, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Zarick, Jr., / 1080 W. Patrick St./ Frederick, Md 21703 | | 31. Date filed (Month, Day, Year) OCT 28 1999 | |
| 32. Registrar's Signature  | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36443

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|--|--|--|--|--|--|---|----|----------------------|------|----------------------------------|--|--|----|-------------------------|-------|----------------------------------|--|--|----|----------------------------------|--|--|----|----------------------------------|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MABEL ALICE ADAMS | | | | | 2. Date of Death Month Day Year NOVEMBER 3, 1999 | | 3. Time of Death 3:15 PM | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital | | | | | 4b. City, Town, or Location of Death Frederick | | 4c. County of Death Frederick | | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 239-62-0338 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 98 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 28, 1901 | | 9. Birthplace (State or Foreign Country) Nebraska | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Frederick | | 10c. City, Town or Location Thurmont | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 10e. Street and Number 7561 Utica Road | | | | 10f. Zip Code 21788 | | 10g. Citizen of What Country? U.S.A. | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nursing | | | 16b. Kind of Business/Industry Health Care | | | | | | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) John David Carlson | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ruby Hixson | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Marilyn Hinson, Daughter | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 132 Clipper Court, Kill Devil Hills, N.C. 27948 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Gardens, Nov. 5, 1999 | | Date Nov. 5, 1999 | | 20c. Location - City or Town, State Frederick, Maryland | | | | | | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee Richard E. Gray M00255 | | | 22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Aspiration Pneumonia</td> <td>Days</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>Cerebrovascular Disease</td> <td>Years</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="3">Due to (or as a consequence of):</td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Aspiration Pneumonia | Days | Due to (or as a consequence of): | | | b. | Cerebrovascular Disease | Years | Due to (or as a consequence of): | | | c. | Due to (or as a consequence of): | | | d. | Due to (or as a consequence of): | | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Aspiration Pneumonia | Days | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. | Cerebrovascular Disease | Years | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier M. Tolino MD | | | | | 29c. License number MD 51610 | | 29d. Date signed (Month, Day, Year) 11-4-99 | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1475 Taney Ave Suite 204 Frederick, MD 21701 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 05 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36444

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Julianna Blessing

2. Date of Death

Month Day Year
Nov 5 1999

3. Time of Death

1:30 p

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Mariner Health of Bel Air

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

215-10-9724

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 7, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Forest Hill

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

#1 Colgate Drive

10f. Zip Code

21050

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George

U/K

Borchard

18. Mother's Name (First, Middle, Maiden Surname)

Margaret

U/K

Stumpner

19a. Informant's Name/Relationship (Type, Print)

Dennis C. Blessing (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1703 Cass Drive, Bel Air, Maryland 21015

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gardens of Faith

Date

Nov. 8, 1999 Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Howard K. McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, complication(s) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

stroke, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

e. Urosequis

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury et

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. M. MD

29c. License number

D34652

29d. Date signed (Month, Day, Year)

November 5, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scott Haswell 2 North Avenue Bel Air Maryland 21014

31. Date filed (Month, Day, Year)

NOV 08 1999

32. Registrar's Signature

Barbara B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36445

Funeral Director

Physician
(Medical Examiner)

1. Decedent's Name (First, Middle, Last)

Carl Leon BAKER

2. Date of Death

Month Day Year
October 30, 1999

3. Time of Death

4:48 PM

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

220-58-4466

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 22, 1951

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

312 East Franklin Street

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
0-12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

out side work

16b. Kind of Business/Industry

car wash

17. Father's Name (First, Middle, Last)

Jack Leon Baker

18. Mother's Name (First, Middle, Maiden Surname)

Carlene Wilkinson

19a. Informant's Name/Relationship (Type, Print)

Mrs. Anna Yost/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Post Office Box 243, Clear Spring, Maryland 21722

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hagerstown Crematory

Date

Nov. 1, 1999

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Minnich Funeral Home

415 East Wilson Blvd., Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Heart Disease

Approximate Interval Between Onset and Death

years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edward W. D. Ditto, III, M.D.

29c. License number

D01062

29d. Date signed (Month, Day, Year)

November 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, MD 21740

State Registrar

31. Date filed (Month, Day, Year)

NOV 02 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36446

| | | | | | | | | | | | | | | | | | | | | | |
|--|---|--------------------------------|---|--|--|--|--|--|---|----|-----------------|--|----|--------------------------|------|----|--------------------------------|--|----|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Delores Arlene BINKLEY | | | | 2. Date of Death Month Day Year OCTOBER 30, 1999 | | 3. Time of Death 3:18 A.M. | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 220-28-8166 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 2, 1931 | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Maugansville | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 14044 Village Mill Drive | | 10f. Zip Code 21767 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) assembly | | 16b. Kind of Business/Industry aircraft | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Frank Roger Hamby | | | | 18. Mother's Name (First, Middle, Maiden Summa) Rosa Mae Wilson | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Darryl L. Binkley - son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7538 McClellan Ave., Boonsboro, Maryland 21713 | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Memorial Park | | 20c. Location - City or Town, State 11/2/99 Hagerstown, Maryland | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee <i>Scott M. Mennick</i> | | | | 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>AORTIC STENOSIS</td> <td>Approximate Interval Between Onset and Death MONTHS</td> </tr> <tr> <td>b.</td> <td>AORTIC VALVE REPLACEMENT</td> <td>DAYS</td> </tr> <tr> <td>c.</td> <td>CORONARY ARTERY BYPASS SURGERY</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | AORTIC STENOSIS | Approximate Interval Between Onset and Death MONTHS | b. | AORTIC VALVE REPLACEMENT | DAYS | c. | CORONARY ARTERY BYPASS SURGERY | | d. | | |
| | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | AORTIC STENOSIS | Approximate Interval Between Onset and Death MONTHS | | | | | | | | | | | | | | | | | |
| b. | | AORTIC VALVE REPLACEMENT | DAYS | | | | | | | | | | | | | | | | | | |
| c. | | CORONARY ARTERY BYPASS SURGERY | | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | | | | | | | | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Harold R. Potholoy, MD</i> | | | | | | | | | | | | | | | | | | | | | |
| 29c. License number D28244 | | | | | | | | | | | | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year) 10-30-99 | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FOWZIA TAQI, M.M., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 02 1999 | | | | | | | | | | | | | | | | | | | | | |
| 32. Registrar's Signature <i>B. Sparks</i> | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36447

| | | | | | | | | | | | |
|---|--|---|---|---|--|---|---|--|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) STANLEY L. BARTH | | | | | | 2. Date of Death Month: Oct Day: 13 Year: 1999 | | 3. Time of Death 11:50 PM | | |
| | 4a. Facility Name (If not institution, give street and number) LORIEN | | | | | | 4b. City, Town, or Location of Death COLUMBIA, MD. | | 4c. County of Death HOWARD | | |
| Funeral Director | 5. Social Security Number 220-30-2357 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 70 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Aug 1, 1929 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Howard | | 10c. City, Town or Location Ellicott City | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 5001 Orchard Drive | | | | 10f. Zip Code 21043 | | 10g. Citizen of What Country? United States | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Diesel Mechanic | | | 16b. Kind of Business/Industry Trucking | | | | |
| | 17. Father's Name (First, Middle, Last) John H. Barth | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lilly M. Porter | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Mae M. Barth/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5001 Orchard Drive Ellicott City, MD 21043 | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Cemetery | | Date 10-18-99 | | 20c. Location - City or Town, State Elkridge, MD | | | | |
| | 21. Signature of Funeral Service Licensee <i>Sam a Collins-Witzke</i> | | | | 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) e. stroke 10/99 Due to (or as a consequence of): f. Cerebrovascular disease 10/99 Due to (or as a consequence of): g. Atrial fibrillation 10/99 Due to (or as a consequence of): h. High blood pressure 10/99 | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Non Small Cell Lung Cancer | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Richard J. Witzke</i> | | 29c. License number 231575 | | 29d. Date signed (Month, Day, Year) October 15, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOLODRUBETZ 9501 Old Maryland Rd Ellicott City, MD 21042 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) OCT 15 1999 | | 32. Registrar's Signature <i>Denise B. Sparks</i> | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

STANDARD 1. DATA
CO-ORDINATE 4-3-64

STANDARD 1. DATA
CO-ORDINATE 4-3-64

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36448

| | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|---|---|----|-----------------------------|----------------------------------|--------------|----|-----------------------|----------------------------------|--------------|----|--|----------------------------------|--|----|--|----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John Wesley Bryant | | | | | 2. Date of Death Month October Day 28 Year 1999 | | 3. Time of Death 2:50 AM | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital | | | | | 4b. City, Town, or Location of Death Frederick | | 4c. County of Death Frederick | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 233-09-7995 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) May 30, 1915 | | 9. Birthplace (State or Foreign Country) Kentucky | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. State S. Carolina | | 10b. County York | | 10c. City, Town or Location Fort Mills | | | | 10d. Inside City Limits 1 Yes 2 No | | | | | | | | | | | | | | | | | | |
| 10e. Street and Number 116 Summersby Street | | | | 10f. Zip Code 29715 | | 10g. Citizen of What Country? United States | | | | | | | | | | | | | | | | | | | | |
| 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative | | | 16b. Kind of Business/Industry Chemical Plant | | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) John Wesley Bryant, Sr. | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Moore, | | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Karl A. Dehn / nephew | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3482 Pleasant Grove Dr. / Ijamsville, MD 21754 | | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Monte Vista Cemetery | | Date 11-1-99 | | 20c. Location - City or Town, State Bluefield, W. Virginia | | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | | 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike / Frederick, MD. 21702 | | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>ASPIRATION PNEUMONIA</td> <td>Due to (or as a consequence of):</td> <td>1 WK.</td> </tr> <tr> <td>b.</td> <td>ACUTE LEUKEMIA</td> <td>Due to (or as a consequence of):</td> <td>1 YR.</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | ASPIRATION PNEUMONIA | Due to (or as a consequence of): | 1 WK. | b. | ACUTE LEUKEMIA | Due to (or as a consequence of): | 1 YR. | c. | | Due to (or as a consequence of): | | d. | | Due to (or as a consequence of): | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | ASPIRATION PNEUMONIA | Due to (or as a consequence of): | 1 WK. | | | | | | | | | | | | | | | | | | | | | | |
| | b. | ACUTE LEUKEMIA | Due to (or as a consequence of): | 1 YR. | | | | | | | | | | | | | | | | | | | | | | |
| | c. | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | |
| | d. | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | | | | | | | | | | | | | | | | |
| | | | | | | | | 24e. Was an autopsy performed? 1 Yes 2 No | | | | | | | | | | | | | | | | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 Medical Examiner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | | 29c. License number D47611 | | 29d. Date signed (Month, Day, Year) OCTOBER 28, 1999 | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEIL WARSHAWSKY MD 1475 TANNEY AVE #204 FREDERICK MD 21702. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) OCT 29 1999 | | 32. Registrar's Signature  | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36449**
Certificate of Death Reg. No.

| | | | | | | | | | | | |
|---|--|---------------------------------|---|---|--|--|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edna Marie Buhrman | | | | | | 2. Date of Death Month November Day 4 , Year 1999 | | 3. Time of Death 10:30 PM | | |
| | 4a. Facility Name (If not institution, give street and number) College View Center | | | | | | 4b. City, Town, or Location of Death Frederick | | 4c. County of Death Frederick | | |
| Funeral Director | 5. Social Security Number 215-18-1128 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 97 Yrs. | | 8. Date of Birth Month Feb. Day 9 , Year 1902 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Frederick | | 10c. City, Town or Location Frederick | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 315 West Seventh Street | | | | 10f. Zip Code 21701 | | 10g. Citizen of What Country? U.S.A. | | | | | |
| 11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | | | |
| 17. Father's Name (First, Middle, Last) Harry Ellis Albaugh | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rosa Measell | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mr. David L. Buhrman, Son | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 West Seventh St., Frederick, Md. 21701 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery, Nov. 8, 1999 | | 20c. Location - City or Town, State Fredederick, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee Richard E. Bray M00255 | | | | | | 22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death 1 wk | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. arteriosclerotic cardiovascular disease | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | | | | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier Austin Pearre, Jr. | | | | | | 29c. License number 009689 | | 29d. Date signed (Month, Day, Year) 11/5/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Austin Pearre, Jr., MD 300 West Ninth Street, Frederick, Maryland 21701 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 05 1999 | | | | 32. Registrar's Signature [Signature] | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36450

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EVA

BOLLINGER

2. Date of Death
Month Day Year
OCTOBER 30, 19993. Time of Death
12:55PM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

220-16-0470

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 5, 1901

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Thurmont

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1 Linda Court

10f. Zip Code

21788

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Owner/Operator

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Jacob Stitely

18. Mother's Name (First, Middle, Maiden Summa)

Mary Elizabeth Freshman

19a. Informant's Name/Relationship (Type, Print)

Sterling E. Bollinger, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 Linda Court Thurmont, Maryland 21788

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Blue Ridge Cemetery

Date

11/3/99

20c. Location - City or Town, State

Thurmont, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Staufer Funeral Homes, P.A.
104 East Main Street Thurmont, Maryland 21788

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Congestive Heart Failure

1 week

Due to (or as a consequence of):

f. Renal Failure

1 week

Due to (or as a consequence of):

g. Aortic Stenosis

years

Due to (or as a consequence of):

h.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shawn Buki, MD, 400 West 7th Street / Frederick, MD 21701

31. Date filed (Month, Day, Year)

NOV 01 1999

32. Registrar's Signature

B. Spack

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

99 36451

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36452

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Douglas

A.

Bloodsworth, Sr.

2. Date of Death

Nov. 1, 1999

3. Time of Death

9:25 AM

4a. Facility Name (If not institution, give street and number)

30350 Oak Street PO Box 103

4b. City, Town, or Location of Death

Princess Anne

4c. County of Death

Somerset

Funeral
Director

5. Social Security Number

218-16-8547

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

02/28/1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Somerset

10c. City, Town or Location

Princess Anne

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

30350 Oak Street PO Box 103

10f. Zip Code

21853

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No WWII
If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
2

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Oyster Grower

16b. Kind of Business/Industry

Seafood

17. Father's Name (First, Middle, Last)

L. Beauchamp Bloodsworth, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Bozman

19a. Informant's Name/Relationship (Type, Print)

Barbara Bloodsworth/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30350 Oak Street, PO Box 103, Princess Anne, Md.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Beechwood Cemetery

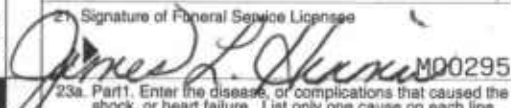
Date

11/4/99

20c. Location - City or Town, State

Princess Anne, Md.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Hinman Funeral Home
11673 Somerset Ave., Princess Anne, Md. 21853

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Cardiomyopathy

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

day
years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

end-stage Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Constante M.D.

29c. License number

16725

29d. Date signed (Month, Day, Year)

11/1/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

TAN, CONSTANCE 507-G Riverside Dr. Salisbury, MD 21801

31. Date filed (Month, Day, Year)

NOV 04 1999

32. Registrar's Signature

Beverly G. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36453

| | | | | | | | | |
|---|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DOROTHY BALLARD | | | | 2. Date of Death Month Day Year October 25 1999 | | 3. Time of Death 09:05 PM. | |
| | 4a. Facility Name (If not institution, give street and number) 32443 Overholt Road | | | | 4b. City, Town, or Location of Death Pocomoke City | | 4c. County of Death Somerset | |
| Funeral Director | 5. Social Security Number 214-30-7769 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) 11-26-22 | |
| | 9. Birthplace (State or Foreign Country) VA | | 10a. State MD | | 10b. County SOMERSET | | 10c. City, Town or Location Pocomoke City | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 Yes 2 No | | 10e. Street and Number 32433 Overholt RD | | 10f. Zip Code 21851 | | 10g. Citizen of What Country? U.S. | |
| | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No | | 14. Race - American Indian, Black, White, etc. Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) 10th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COOK | | 16b. Kind of Business/Industry Bus Terminal | | | |
| | 17. Father's Name (First, Middle, Last) UNKNOWN | | 18. Mother's Name (First, Middle, Maiden Surname) Virginia Cornish | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Jimmie Mae Copes - Niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 914 Roger ST. Salisbury, MD 21804 | | | |
| | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHRIST M.E. Church Cem. | | 20c. Location - City or Town, State 11-2-99 Pocomoke, MD | | 20d. Date | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Anthony E. Waulf | | | | 22. Name and Address of Facility Anthony E. Waulf Funeral Home 30639 Hampton Ave. Princess Anne, MD 21853 | | | |
| | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arteriosclerotic Cardiovascular Disease | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 Yes 2 No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | |
| | 25. Was case referred to medical examiner? 1 Yes 2 No | | | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier John L. Loefer | | | |
| | 29c. License number O.C.M.E. | | | | 29d. Date signed (Month, Day, Year) October 28, 1999 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUDITH L. Loefer MD 111 Penn Street, Baltimore, Maryland 21201 | | | | 31. Date filed (Month, Day, Year) NOV 03 1999 | | | |
| | 32. Registrar's Signature Benita B. Sparks | | | | 33. Date of Death (Month, Day, Year) October 25, 1999 | | | |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Lines

State of Maryland / Department of Health and Mental Hygiene

5. and 10c. SC WCHD 11-9-99

Certificate of Death

Reg. No.

99 36454

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen

Lee

CURFMAN

2. Date of Death

Month

Day

Year

Nov. 5, 1999

3. Time of Death

06:45 PM

4a. Facility Name (If not institution, give street and number)

Coffman Nursing Home

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

WASHINGTON

Funeral
Director

5. Social Security Number

2189 219-36-3906

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

June 24, 1903

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Williamsport

Williamsport

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

16505 Virginia Ave.

10f. Zip Code

21795

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Charles

Lee

Curfman

18. Mother's Name (First, Middle, Maiden Surname)

Annie

Cecilia McCardell

19a. Informant's Name/Relationship (Type, Print)

Delancy Cattlett

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

144 N. Artizan St. Williamsport, MD 21795

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Riverview Cemetery Nov. 9, 1999

Date

20c. Location - City or Town, State

Williamsport, MD 21795

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

OSBORNE FUNERAL HOME

P.O. Box # 348 Williamsport, MD 21795

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

2 Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advanced Dementia
Atherosclerotic Cardiovascular
Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
Investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Samuel Chan

29c. License number

D 36655

29d. Date signed (Month, Day, Year)

Nov. 8 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMUEL CHAN, M.D. - 1185 Mt Aetna Rd. HAGERSTOWN, MD 21740

State
Registrar

31. Date filed (Month, Day, Year)

NOV 09 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36455

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Edna Coy

2. Date of Death

October 20, 1999

Day

Year

3. Time of Death

10:30 AM

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

5. Social Security Number

458-62-6952

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec 26, 1914

9. Birthplace (State or Foreign Country)

Arkansas

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9592 Muirkirk Road #T1

10f. Zip Code

20708

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Navar Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Community College

17. Father's Name (First, Middle, Last)

Patrick Henry Coy

18. Mother's Name (First, Middle, Maiden Summa)

Susan Katherine Weaver

19a. Informant's Name/Relationship (Type, Print)

Ruth Coy /niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9592 Muirkirk Road #T1, Laurel, Maryland 20708

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory, Inc.

Date

10/22/99 Catonsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donaldson Funeral Home, P.A.

313 Talbott Ave. Laurel, Maryland 20707-4389

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Sepsis
Due to (or as a consequence of):

2 days

b. Stroke
Due to (or as a consequence of):

1 month

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastc. Pulmonary edema
Due to (or as a consequence of):

2 days

d. Acute renal failure
Due to (or as a consequence of):

2 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicida
4 ☐ Homicida

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

043237

29d. Date signed (Month, Day, Year)

October 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Armstrong 14201 Laurel PK Dr #102 Laurel MD 20707

State
Registrar

31. Date filed (Month, Day, Year)

OCT 22 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#2 per doctor, 11/3/1999 Certificate of Death FCHD, KS

Reg. No.

99 36456

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Joseph Callahan, Jr.

2. Date of Death
Month Day Year
October 16, 1999
8:25 p.m.Funeral
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

024-30-1142

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 27 1940

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State
Maryland10b. County
Montgomery10c. City, Town or Location
Germantown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18806 Bent Willow Circle

10f. Zip Code

20874

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5 +

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Director of Device Division

16b. Kind of Business/Industry

U.S. Governemtn
F D A

17. Father's Name (First, Middle, Last)

Thomas J. Callahan, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Lynch

19a. Informant's Name/Relationship (Type, Print)

Patricia E. Brinson / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

110 Bugle Ct./ Leesburg, VA 20176

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. St. Marys Col. Cem.

Date

10-22-99

20c. Location - City or Town, State

Emmitsburg, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike/ Frederick, MD 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Acute Myocardial Infarctions

Approximate
Interval Between
Onset and Death

Minutes

e. Due to (or as a consequence of):

Coronary Artery Disease

Years

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

033261

29d. Date signed (Month, Day, Year)

Oct 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Dooley, MD / 9901 Medical Center Dr./ Rockville, MD 20850

State
Registrar

31. Date filed (Month, Day, Year)

OCT 20 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36457

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ann Cassis

2. Date of Death

Month Day Year
October 31, 1999

3. Time of Death

7:00 AM

4a. Facility Name (If not institution, give street and number)

Homewood Nursing Retirement Center

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

578-07-9179

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 13, 1909

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

31 West Patrick Street

10f. Zip Code

21701

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

self

16b. Kind of Business/Industry

homemaker

17. Father's Name (First, Middle, Last)

Joseph Seller

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ellen Hardee

19a. Informant's Name/Relationship (Type, Print)

Steve H. Cassis, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11449 Alton Road, Frederick, MD 21701

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Smithsburg Crematory

Date

11/1/99

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

Rip M. Berger

22. Name and Address of Facility

Keeney and Basford Funeral Home
MO0999 106 East Church Street, Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

NA

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John A. Shutta MD

29c. License number

D30020

29d. Date signed (Month, Day, Year)

11/1/99

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

John A. Shutta, MD, PO Box 310, Walkersville, Maryland 21793

31. Date filed (Month, Day, Year)

NOV 02 1999

32. Registrar's Signature

John A. Shutta

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended line#29d 11/3/99 FCHD KS Certificate of Death

Reg. No. 99 36458

| | | | | | | | | | | | |
|--|---|--|---|---|--|---|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CATHERINE MARIETTA CARLISLE | | | | | | 2. Date of Death Month Day Year October 30, 1999 | | 3. Time of Death 7:17 AM | | |
| | 4a. Facility Name (If not institution, give street and number) Northampton Manor Nursing Home | | | | | | 4b. City, Town, or Location of Death Frederick | | 4c. County of Death Frederick | | |
| Funeral Director | 5. Social Security Number 214-10-1157 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | | 8. Date of Birth (Month, Day, Year) June 22, 1909 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Frederick | | 10c. City, Town or Location Frederick | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 200 East Sixteenth Street | | | | 10f. Zip Code 21701 | | 10g. Citizen of What Country? U.S.A. | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Counselor | | | 16b. Kind of Business/Industry MD School for the Deaf | | | | |
| 17. Father's Name (First, Middle, Last) Hiley Summers Orndorff | | | | | | 18. Mother's Name (First, Middle, Maiden Summa) Sadie Michael | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Phyllis Schilling (Niece) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7196 Stillwater Court, Frederick, Maryland 21702 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery | | 20c. Location - City or Town, State 11/2/99 Frederick, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Dementia, Alzheimer's type Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death 10 y. | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D17106 | | 29d. Date signed (Month, Day, Year) November 1, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael S. Rudman, MD 5 Church & Franklin Streets, Middletown, MD 21769 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 01 1999 | | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36459

| | | | | | | | |
|---|---|---|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mildred Lydia Crawford | | | | 2. Date of Death Month Day Year October 29, 1999 | | 3. Time of Death 7:30 am |
| | 4a. Facility Name (If not institution, give street and number) Shady Grove Nursing Center | | | | 4b. City, Town, or Location of Death Rockville | | 4c. County of Death Montgomery |
| Funeral Director | 5. Social Security Number 215-62-6322 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | 8. Date of Birth (Month, Day, Year) June 22, 1914 | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Frederick | 10c. City, Town or Location Adamstown | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 5685 Mountville Road | | 10f. Zip Code 21710 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | |
| | 17. Father's Name (First, Middle, Last) Felix Lorenzo Plunkert | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mamie Elizabeth Cutsail | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Mrs. Linda L. Davis, daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14514 Banquo Terrace, Silver Spring, Md. 20906 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery, Nov. 1, 1999 | | 20c. Location - City or Town, State Frederick, Maryland | | |
| | 21. Signature of Funeral Service Licensee Richard E. Prof M00255 | | 22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | Approximate Interval Between Onset and Death few weeks |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Hypertension Cardiac Dysrhythmia | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier G. Gupta, MD | | | | 29c. License number D 46398 | | 29d. Date signed (Month, Day, Year) October 30, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. Gupta, MD 121 Congressional Lane, #409, Rockville, MD 20852 | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 03 1999 | | 32. Registrar's Signature B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36460

Neva Cornine SS # 218-16-6747 Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|---|---|---|--------------------------------|--|--|
| Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last) NEVA WEST CORNINE | | | | 2. Date of Death Month Day Year November 2, 1999 | | 3. Time of Death 0015 | |
| 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death WICOMICO | |
| 5. Social Security Number 218-16-6747 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 93 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) April 26, 1906 | |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| Usual Residence of Decedent 10a. State: Maryland 10b. County: Wicomico 10c. City, Town or Location: Salisbury | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 104 Hillside Dr. | | | | 10f. Zip Code 21804 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 11 College (1-4 or 5+): - | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesperson | | 16b. Kind of Business/Industry Retail Sales | |
| 17. Father's Name (First, Middle, Last) James R. West | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ethel Lee Parsons | | | |
| 19a. Informant's Name/Relationship (Type, Print) Lance R. Cornine/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1207 Pennypacker Lane, Bowie, MD 20716 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parsons Cemetery | | Date 11/6/99 | | 20c. Location - City or Town, State Salisbury, MD | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. COPD Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration, Anorexia, Obstipation, metabolic Acidosis | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) M | | 28b. Time of Injury 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number A18614 | | 29d. Date signed (Month, Day, Year) 11-2-99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deepak Saggan, M.D. 547 E. Riverside Dr. Salisbury, MD | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 04 1999 | | | | 32. Registrar's Signature | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

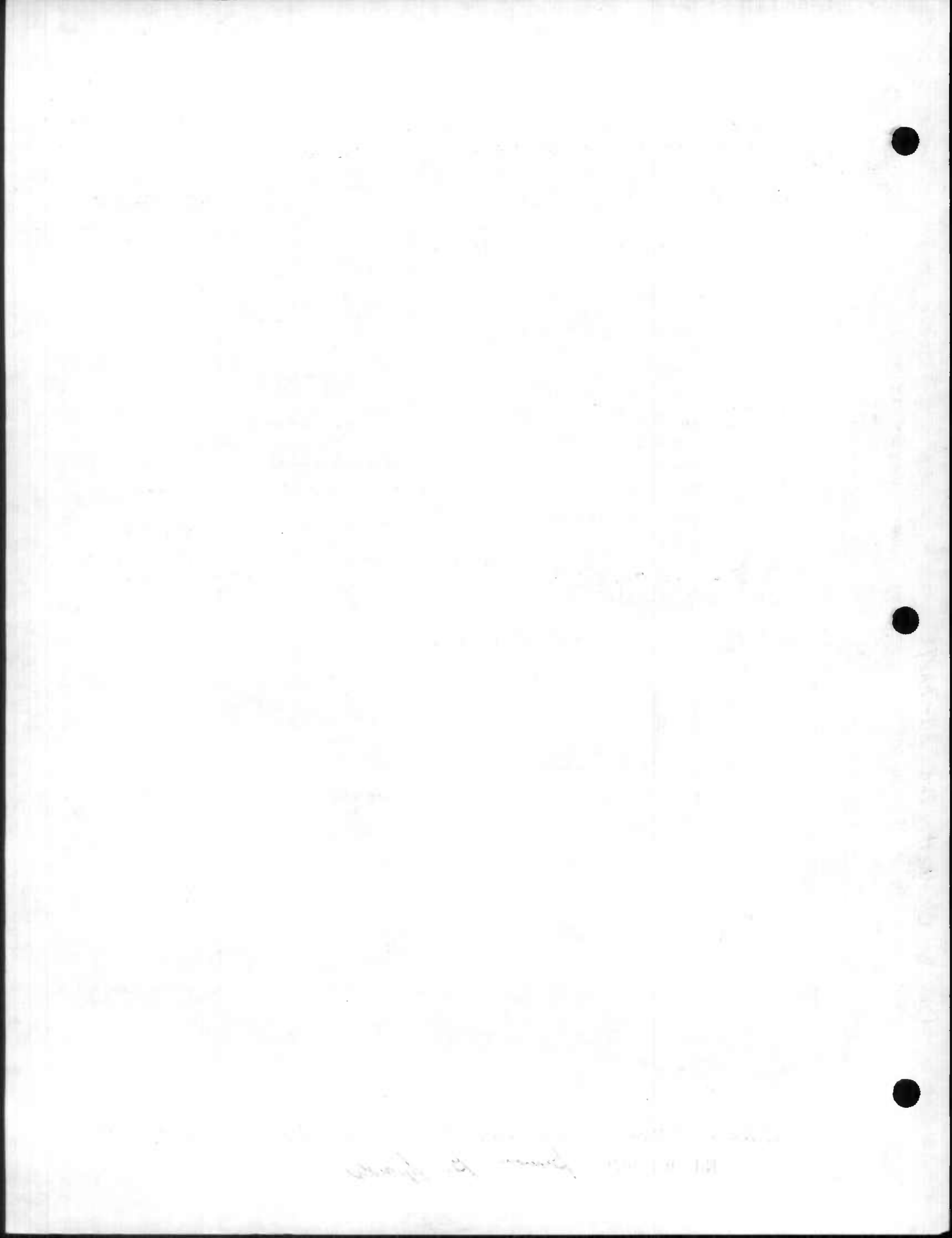
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 35461

| | | | | | | | | | | |
|---|---|--|---|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DONALD BRYAN CROCKETT | | | | | | 2. Date of Death Month Day Year October 29 1999 | | 3. Time of Death 0600 | |
| | 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death WICOMICO | |
| Funeral Director | 5. Social Security Number 220-32-9467 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 Yrs. | | 8. Date of Birth (Month, Day, Year) July 16, 1931 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Wicomico | | 10c. City, Town or Location Fruitland | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 416 W. Main St. | | | | 10f. Zip Code 21826 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Navy Korea | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) - | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Route Salesman | | | 16b. Kind of Business/Industry Baking co. | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) W. Bryan Crockett | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Madeline Pusey | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mary Louise Crockett/Wife | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 W. Main St., Fruitland, MD 21826 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Memory Gardens | | 20c. Date 11/1/99 | | 20d. Location - City or Town, State Hebron, MD | | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | | | 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>[Signature]</i> Due to (or as a consequence of): <i>[Signature]</i> Due to (or as a consequence of): <i>[Signature]</i> Due to (or as a consequence of): <i>[Signature]</i> | | | | | | | | Approximate Interval Between Onset and Death <i>[Signature]</i> <i>[Signature]</i> | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>[Signature]</i> <i>[Signature]</i> | | | | | | | | 23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number 029349 | | 29d. Date signed (Month, Day, Year) 10/29/99 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Robin's, M.D. 1104 HEATHWAY W. SALISBURY, MD | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) NOV 01 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99-36462

| | | | | | | | | | | |
|--|--|---|--|--|--|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOHN HOWARD COMBS | | | | | | 2. Date of Death Month Day Year October 31, 1999 | | 3. Time of Death 0615 | |
| | 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death WICOMICO | |
| Funeral Director | 5. Social Security Number 219-07-7024 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) FEB. 28, 1916 | | 9. Birthplace (State or Foreign Country) MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MARYLAND | | 10b. County WORCESTER | | 10c. City, Town or Location BERLIN | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 9108 CEDAR LANE ROAD | | | | 10f. Zip Code 21811 | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ENGINEER | | | 16b. Kind of Business/Industry MANUFACTURING | | | |
| 17. Father's Name (First, Middle, Last) JOHN COMBS | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) MAUDE ELLIOTT | | | | |
| 19a. Informant's Name/Relationship (Type, Print) DOROTHY W. COMBS/WIFE | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9108 CEDAR LANE ROAD, BERLIN, MARYLAND 21811 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) NEW HOPE CEMETERY | | | Date 11/3/99 | | 20c. Location - City or Town, State WILLARDS, MARYLAND | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | | | 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. <u>hemorrhage</u> Due to (or as a consequence of): b. <u>Rupture of thoracoabdominal aneurysm</u> Due to (or as a consequence of): c. <u>Rupture of thoracoabdominal aneurysm</u> Due to (or as a consequence of): d. <u>Atherosclerosis</u> Approximate interval between Onset and Death 6 hrs 12 hrs | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>hypertension;</u> <u>Coronary Artery disease</u> | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number D0053551 | | 29d. Date signed (Month, Day, Year) 10-31-99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. James Todd 201 Pine Bluff Rd. Suite 25, Salisbury, Md 21801 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 01 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36463

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE WILLIAM DRAPER

2. Date of Death

October 29 1999

3. Time of Death

0502

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington County

Funeral
Director

5. Social Security Number

214-09-7376

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 7, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1138 Cottage Court

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collega (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Aircraft Manufacturer

17. Father's Name (First, Middle, Last)

Jesse Wolford Draper

18. Mother's Name (First, Middle, Maiden Summa)

Mary Kitzmiller

19a. Informant's Name/Relationship (Type, Print)

Hilda Iona Draper, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1138 Cottage Court, Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rest Haven Cemetery

Date

Nov. 1

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

K. A. Zimmerman

22. Name and Address of Facility

Douglas A. Fiery Funeral Home
1331 Eastern Blvd. N., Hagerstown, Maryland 2174223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Cardiorespiratory Failure

Approximate
Interval Between
Onset and Death

Few hours

Due to (or as a consequence of):

b.

Hydrocephalous with

Few years

Due to (or as a consequence of):

c.

Intracranial Shunt

Due to (or as a consequence of):

d.

Hypertension

Few years

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D. A. Kachand

29c. License number

D35497

29d. Date signed (Month, Day, Year)

10.29.99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JANUIR A. PASHA MD 376 Mill St. Hagerstown

State
Registrar

31. Date filed (Month, Day, Year)

NOV 01 1999

32. Registrar's Signature

B. Sparks

MD, 21740

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitGeorge William Draper
Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36464

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Cloe Estella Dietrich

2. Date of Death

October 27

Day

Year

1999

3. Time of Death

11:55 pm

4a. Facility Name (If not institution, give street and number)

Colton Villa Nursing Home

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

188-10-0563

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 21, 1917

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

13604 Greencastle Pike

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teller

16b. Kind of Business/Industry

Bank

17. Father's Name (First, Middle, Last)

Irvin Huston Miller

18. Mother's Name (First, Middle, Maiden Surname)

Florence Jeanetta Bishop

19a. Informant's Name/Relationship (Type, Print)

Jesse Dietrich Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13604 Greencastle Pike Hagerstown, Maryland 21740

20e. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

Date

10-30-99 Hagerstown, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Osborne Funeral Home, P.A.

425 S. Conococheague St. Williamsport, MD 21795

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

RENAL FAILURE

e. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 years

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. DIABETES MELLITUS

Due to (or as a consequence of):

10 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D28365

29d. Date signed (Month, Day, Year)

10-28-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAN 2nd J SHAPIRO 3680111111 STREET HAGERSTOWN MD 21740

31. Date filed (Month, Day, Year)

OCT 29 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36465

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar
 DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Sue Ann DENEEN | | | | 2. Date of Death Month Day Year Nov. 1 1999 | | | | 3. Time of Death 12:21 p.m. | | | |
| 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | | | 4b. City, Town, or Location of Death Hagerstown | | | | 4c. County of Death Washington | | | |
| 5. Social Security Number 217-86-1066 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 36 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 3 1962 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Hagerstown | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 12001 S. Scottish Court | | | | 10f. Zip Code 21740 | | | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Her own home | | | |
| 17. Father's Name (First, Middle, Last) Robert Mumma, Jr. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Stella Mason | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Robert Mumma, Jr. - Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17336 W. Washington Street Hagerstown, Md. 21740 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery | | | | Date 11/6/99 | | 20c. Location - City or Town, State Hagerstown, Maryland | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. Diabetes mellitus Due to (or as a consequence of): c. Renal transplant Due to (or as a consequence of): d. End Stage Renal disease | | | | | | | | | | Approximate Interval Between Onset and Death 48 Hours | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Morbidly obesity | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D53548 | | | | 29d. Date signed (Month, Day, Year) 11-1-99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Mohammed Monzur, 12931 Oak Hill Ave., Hagerstown, Md. 21742 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 03 1999 | | | | 32. Registrar's Signature | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36466

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Manon DARR

2. Date of Death

Month Day Year
October 31, 1999

3. Time of Death

2:45 p.m.

4a. Facility Name (If not institution, give street and number)

Coffman Nursing Home

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

214-09-5778

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 3, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

11 W. Baltimore Street Apt. 716

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

laborer

16b. Kind of Business/Industry

aircraft

17. Father's Name (First, Middle, Last)

Martin Luther Drenner

18. Mother's Name (First, Middle, Maiden Surname)

Anna E. Bowers

19a. Informant's Name/Relationship (Type, Print)

Joy Heil - sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10914 Lincoln Avenue Hagerstown, Maryland 21740

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rest Haven Cemetery

Date

11-3-99

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

2 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerosis systemic disease
Hypertension
Atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Pending investigation☐ Accident☐ Suicide☐ Homicide☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Samuel Chan

D36655

Nov. 1st 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMUEL CHAN, MD 1185 MT AETNA RD HAGERSTOWN, MD

21740

State
Registrar

31. Date filed (Month, Day, Year)

NOV 02 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36467

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

David Robert Durst

2. Date of Death

Month
Nov.Day
09Year
1999

3. Time of Death

1:35 a.m.

4a. Facility Name (If not institution, give street and number)

Colton Villa Nursing Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington County

Funeral
Director

5. Social Security Number

213-16-9404

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 3, 1920

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington Co.

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☐ Yes ☐ No

10e. Street and Number

11233 Lakeside Drive

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give Year or Dates: 11/26/44
11/18/4513. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

President

16b. Kind of Business/Industry

Electronics Company

17. Father's Name (First, Middle, Last)

David Anthony Durst

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Marie Edwards

19a. Informant's Name/Relationship (Type, Print)

Mary Vivian Durst/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11233 Lakeside Drive, Hagerstown, Maryland 21740

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Smithsburg Crematory

Date

Nov. 9

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Douglas A. Fiery Funeral Home
1331 Eastern Blvd., N., Hagerstown, Maryland 2174223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Multi-infarct dementia

Due to (or as a consequence of):

b. Peripheral vascular disease

Due to (or as a consequence of):

c. S/P Right AAA

Due to (or as a consequence of):

d. S/P cerebral vascular accident

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's disease

HASCVD

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JERRY L. CORREAS, M.D.

338 min st.
Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

NOV 16 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36468

| | | | | | | | | | | |
|--|---|---------------------------|---|--|--|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Barbara June Deason | | | | | | 2. Date of Death Month Day Year November 9, 1999 | | 3. Time of Death 0400 | |
| | 4a. Facility Name (If not institution, give street and number) 228 Summit Avenue | | | | | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington | |
| Funeral Director | 5. Social Security Number 444-30-8754 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 66 Yrs. | | 8. Date of Birth (Month, Day, Year) February 14, 1933 | | 9. Birthplace (State or Foreign Country) Oklahoma | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Hagerstown | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number 228 Summit Avenue | | | | 10f. Zip Code 21740 | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Home | | | |
| 17. Father's Name (First, Middle, Last) Victor Chester Dake | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Georgia Irene Hail | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Edward W. Tapp Son | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47 E. North Ave., Apt. 3 Hagerstown, Maryland 21741 | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory | | 20c. Location - City or Town, State Hagerstown, Maryland | | 20d. Date 11/9/99 | | | |
| 21. Signature of Funeral Service Licensee <i>Gerald N. Minnich</i> | | | | | | 22. Name and Address of Facility Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland 21740 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cerebral vascular accident</u> Due to (or as a consequence of): b. <u>hypertension</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death <u>immediate</u> <u>30 yrs</u> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>asthma</u> | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier <i>[Signature]</i> | | | 29c. License number D0043389 | | 29d. Date signed (Month, Day, Year) 11/9/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Susan Brinkley, 11110 Medical Campus Rd Suite 226 HAGERSTOWN MD 21742 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 09 1999 | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36469

| | | | | | | | | |
|---|---|--|---|---|--|--|--|-----------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Deborah Lynn Drechsler | | | | | 2. Date of Death Month Day Year OCT. 24, 1999 | | 3. Time of Death 0630 AM |
| | 4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | 4c. County of Death ANNE ARUNDEL | |
| Funeral Director | 5. Social Security Number 213-54-9077 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 48 Yrs. | 8. Date of Birth (Month, Day, Year) March 28, 1951 | 9. Birthplace (State or Foreign Country) Maryland | | | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md. | 10b. County Anne Arundel | 10c. City, Town or Location Severn | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number 7810 Walnut Tree Road | | 10f. Zip Code 21144 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Parts Manager | | 16b. Kind of Business/Industry Auto Parts Store | | | |
| | 17. Father's Name (First, Middle, Last) James Lonaberger | | | | 18. Mother's Name (First, Middle, Maiden Surname) Helen Fertenbaugh | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Gerald Drechsler/Spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7810 Walnut Tree Road Severn, Maryland 21144 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | 20c. Location - City or Town, State Catonsville, Md. | | | |
| | 21. Signature of Funeral Service Licensee G. S. K. | | 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Head Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 10-24-99 | | 28b. Time of Injury 0341 M | | 28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street - Rt. 3 NB near McKnew Rd, Crofton, MD | | 28d. Describe how injury occurred driver who lost control + hit tree without | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier J. Pestaner, M.D. | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) OCT. 25, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) OCT 26 1999 | | 32. Registrar's Signature Benita B. Sparks | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36470

| | | | | | | | | | | |
|--|--|---|--|---|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Barbara Shriver Devereux | | | | 2. Date of Death Month Day Year October 15 1999 | | | | 3. Time of Death 11:55pm | |
| | 4a. Facility Name (If not institution, give street and number) 5701 B Harpers Farm Road | | | | 4b. City, Town, or Location of Death Columbia | | | | 4c. County of Death Howard | |
| Funeral Director | 5. Social Security Number 219-20-9703 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) May 31, 1924 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Howard | | 10c. City, Town or Location Columbia | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 5701 B Harpers Farm Road | | | | 10f. Zip Code 21044 | | | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Own Home | | |
| 17. Father's Name (First, Middle, Last) William H. Shriver | | | | 18. Mother's Name (First, Middle, Maiden Surname) Hannah McCormick | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) John Ryan Devereux III/Spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5701 B Harpers Farm Road Columbia, MD 21044 | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Louis Cemetery | | 20c. Location - City or Town, State 10-19-99 Clarksville, MD | | | | |
| 21. Signature of Funeral Service Licensee Sharon A. Collins-Witzke | | | | 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Respiratory Failure Due to (or as a consequence of): b. Multifocal lung mets Due to (or as a consequence of): c. Pancreatic Cancer - neuroendocrine Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Emphysema, Anorexia-Cachexia. Chronic anemia | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier Jon K. Minnick, MD. | | | | 29c. License number D30573 | | | | 29d. Date signed (Month, Day, Year) 70-18-99 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Jon K. Minnick, MD. | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) OCT 18 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36471

Amended line 10afchd, jd

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Josephine F. Darby

2. Date of Death

Month Day Year
October 27, 1999

3. Time of Death

12:30 AM

4a. Facility Name (If not institution, give street and number)

Northampton Manor Nursing Home

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

218-30-2513

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 20, 1902

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

305 E. Third Street

10f. Zip Code

21701

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

self

16b. Kind of Business/Industry

homemaker

17. Father's Name (First, Middle, Last)

William Noble Darby

18. Mother's Name (First, Middle, Maiden Surname)

Isabell Dodge

19a. Informant's Name/Relationship (Type, Print)

Paul Darby, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

305 E. Third Street, Frederick, Maryland 21701

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Smithsburg Crematory

Date

10/28/99 Smithsburg, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Michael C. Stoller

22. Name and Address of Facility

Scarpelli Funeral Home, PA
108 Virginia Ave., Cumberland, Maryland 2150223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. *Rectal Carcinoma*
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb.
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death*month*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Depression

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ronald Miller, MD

29c. License number

D26499

29d. Date signed (Month, Day, Year)

10-27-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ronald Miller, MD, PO Box 210, Mt. Airy, MD 21771

31. Date filed (Month, Day, Year)

OCT 28 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36472

| | | | | | | | | | | |
|--|---|--|---|--------------------------------|--|--|---|---|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CHARLES FRANK DICKENS | | | | 2. Date of Death Month Day Year OCTOBER 27, 1999 | | 3. Time of Death 4:10 AM | | | |
| | 4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital | | | | 4b. City, Town, or Location of Death Frederick | | 4c. County of Death Frederick | | | |
| Funeral Director | 5. Social Security Number 072-09-0745 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 86 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) April 2, 1913 | 9. Birthplace (State or Foreign Country) New York | | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Frederick | 10c. City, Town or Location New Market | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 10e. Street and Number 137 W. Main St | | | 10f. Zip Code 21774 | | 10g. Citizen of What Country? U.S.A. | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-45 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Title Insurance Officer | | | 16b. Kind of Business/Industry Insurance | | | | |
| | 17. Father's Name (First, Middle, Last) Charles Dickens | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary MacArthur | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Anne Dickens / wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 137 W. Main St, PO Box 266, New Market, MD 21774 | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Mem. Gardens Crematory | | 20c. Location - City or Town, State Frederick, MD | | 20d. Date 10/28/99 | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility J.N. Zumbun F.H. 6028 Sykesville Rd, Eldersburg, MD 21784 | | | | | |
| | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Arrest Due to (or as a consequence of): Respiratory Arrest Due to (or as a consequence of): Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 4 days | | | | | | | Approximate Interval Between Onset and Death 10 min 15 min 4 days | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier  Alan Rohrer, MD | | | | 29c. License number D37197 | | 29d. Date signed (Month, Day, Year) 10-27-99 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ALAN H. ROHRER, MD, 1080 W. Patrick St, Frederick, MD 21703 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) OCT 29 1999 | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36473

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Scott Franklin Dodson

2. Date of Death

November 3 1999 12:30 pm

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

215-20-2999

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jan 9, 1925

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

12202 Lakeview Drive

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Montgomery County
Government

17. Father's Name (First, Middle, Last)

William

Dodson

18. Mother's Name (First, Middle, Maiden Surname)

Mary

(unknown)

19a. Informant's Name/Relationship (Type, Print)

Elsie Gill Dodson - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12202 Lakeview Drive, Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parklawn Memorial Park

Date

11/06/99

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

Paul L. Williams

22. Name and Address of Facility

Olin L. Molesworth P.A., Funeral Home

26401 Ridge Road, Damascus, Maryland 20872-0117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Branchogenic Carcinoma
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

Months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. _____
Due to (or as a consequence of):c. _____
Due to (or as a consequence of):

d. _____

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Paul L. Williams

29c. License number

D21457

29d. Date signed (Month, Day, Year)

11-4-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABOUL WAHEED MD - 12821 OAKHILL AVE. HAGERSTOWN MD 21742

State
Registrar

31. Date filed (Month, Day, Year)

NOV 05 1999

32. Registrar's Signature

B. Spaulding

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitDivision of Vital Records, P.O. Box 68760,
Scott Franklin Dodson

99 36474

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Pauline Elizabeth Drummond</i> | | | | 2. DATE OF DEATH MONTH <i>11</i> DAY <i>05</i> YEAR <i>99</i> | | 3. TIME OF DEATH <i>5⁰⁰ P M</i> | |
| 4. SOCIAL SECURITY NUMBER <i>218-14-4332</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (in yrs. last birthday) <i>80</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>3-8-19</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>DELAWARE</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>218-14-4332/MANOKIN Manor N.H.</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Princess Anne</i> | |
| 9c. COUNTY OF DEATH <i>SOMERSET</i> | | | | 10a. STATE <i>MD</i> | | 10b. COUNTY <i>Somerset</i> | |
| 10c. CITY, TOWN OR LOCATION <i>DAMES QUARTER</i> | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER <i>10870 Rieg Roberts RD</i> | |
| 10f. ZIP CODE <i>21821</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S</i> | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8th</i> College (1-4 or 5+) <i></i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>LABORER</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Farm / Orchard</i> | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Robert Wright</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Louise Johnson</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Lester J. Ward</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>11801 Kimberly Woods Lane Ft. Washington, MD 20744</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Macedonia U.M.C. Cemetery 11/2/99</i> | | 20c. LOCATION — City or Town, State <i>DAMES QUARTER, MD</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Anthony E. Ward</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Anthony E. Ward Funeral Home 30639 Hampton Ave. Princess Anne, MD 21853</i> | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Intraoperative Sarcoma, Advanced</i> | | | | | |
| | | b. <i>with Duodenal Fistula</i> | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Severe Anemia</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gregorio M. Bellosi, M.D.</i> | | | | 29c. LICENSE NUMBER <i>D-29505</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>11-6-99</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>GREGORIO M. BELLOSO, M.D. 5302 CHINABERRY DR. SALISBURY, MD 21801</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>NOV 08 1999</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Barbara A. Sparks</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760
 BALTIMORE, MARYLAND 21215-0020
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36475

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---------------------------------|--|--|--|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Willie Mae Dallas | | | | | 2. Date of Death Month October Day 28 Year 1999 | | 3. Time of Death 1241 | |
| | 4a. Facility Name (If not institution, give street and number) Peninsula Regional Medical Center | | | | | 4b. City, Town, or Location of Death Salisbury | | 4c. County of Death Wicomico | |
| Funeral Director | 5. Social Security Number 215-44-6548 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 54 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 18, 1945 | | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State MD | | 10b. County Worcester | | 10c. City, Town or Location Newark | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 6226 Basketwitch Rd. | | | | | 10f. Zip Code 21841 | | 10g. Citizen of What Country? U.S. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer | | | 16b. Kind of Business/Industry Electronic | | |
| 17. Father's Name (First, Middle, Last) James Powell | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Gladys Mae Loadholt | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Lanetta Dallas/daughter | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 Beaglin Park Drive, Salisbury, MD 21804 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Wesley UMC Cemetery | | Date 11/4/99 | | 20c. Location - City or Town, State Snow Hill, MD | | |
| 21. Signature of Funeral Service Licensee | | | | | 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | Approximate Interval Between Onset and Death |
| a. myocardial infarction Due to (or as a consequence of): b. Diabetes Mellitus Due to (or as a consequence of): c. Cardiomyopathy Due to (or as a consequence of): d. | | | | | | | | | 1 hr. 10 yrs 5 yrs |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier | | | 29c. License number D46490 | | 29d. Date signed (Month, Day, Year) 11-2-99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 428 W. Market St Snow Hill, MD 21803 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 02 1999 | | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

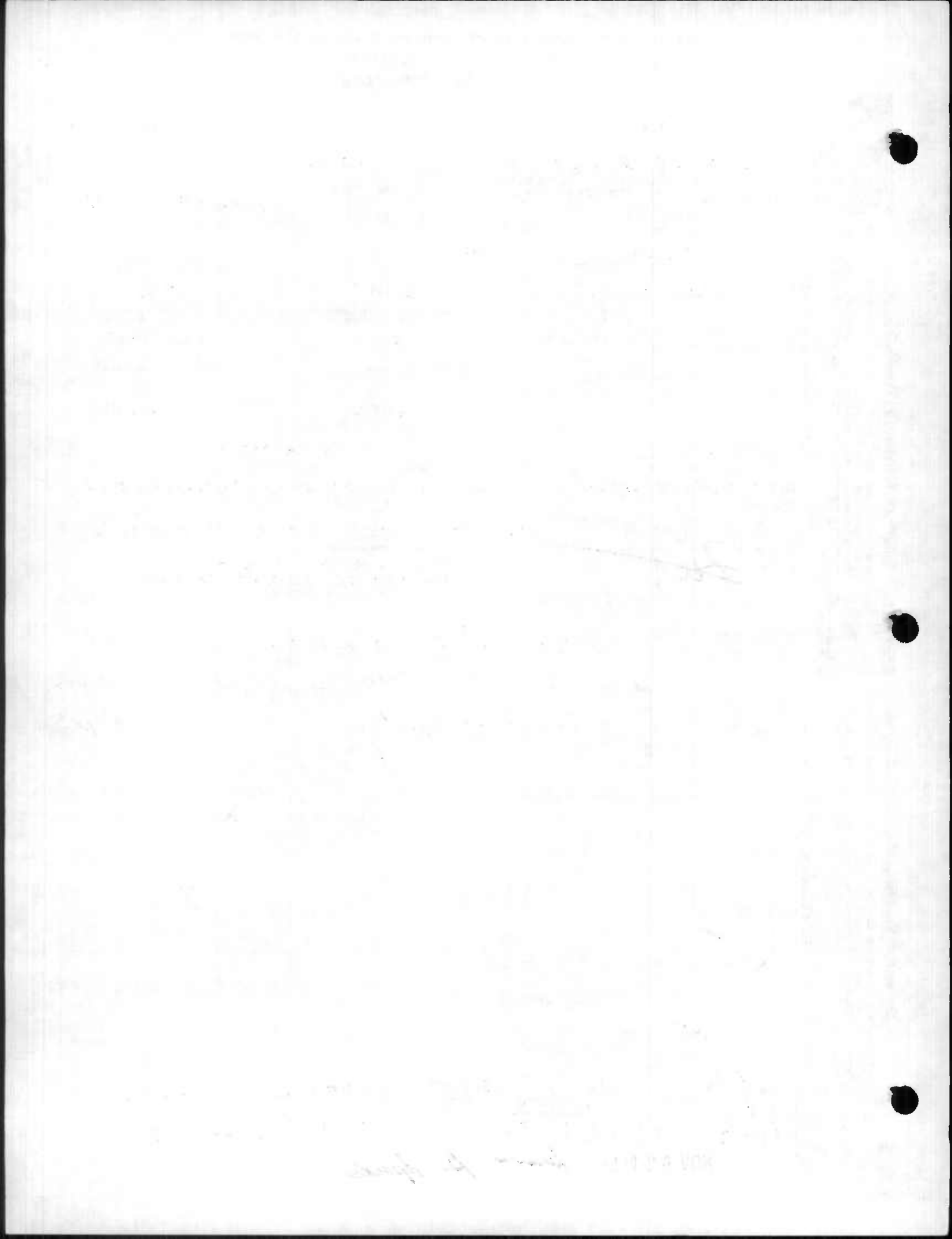
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36476

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Arvin Laray Eby | | | | 2. Date of Death Month Day Year November 04 1999 | | 3. Time of Death 12:10 PM. | |
| | 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington | |
| Funeral Director | 5. Social Security Number | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 16 Yrs. | 8. Date of Birth (Month, Day, Year) August 30, 1983 | 9. Birthplace (State or Foreign Country) Maryland | | | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD. | 10b. County Washington | 10c. City, Town or Location Williamsport | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 14256 Clear Spring Rd. | | | 10f. Zip Code 21795 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farm Work | | | 16b. Kind of Business/Industry Agriculture | | |
| | 17. Father's Name (First, Middle, Last) C. Lester Eby Sr. | | | | 18. Mother's Name (First, Middle, Maiden Summa) Doris M. Eby | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Carl L. Eby Jr. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17009 Broadfording Rd. Hagerstown, Md. 21740 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Clear Spring Mennonite Church Cemetery | | 20c. Location - City or Town, State Clear Spring, Md. | | | |
| | 21. Signature of Funeral Service Licensee H. Martin Zimmerman Jr. | | | | 22. Name and Address of Facility Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. 17225 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Injuries of Torso and (Due to (or as a consequence of): b. Compressional Asphyxia (Due to (or as a consequence of): c. (Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month/Day/Year) 11/4/99 | | 28b. Time of Injury 11:15 AM | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Farm/Home; 14256 Clear Spring Rd; Williamsport, Md | | | | 28d. Describe how injury occurred Subject had mobile home fall on self. | | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Joseph Pestaner, M.D. | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) November 5, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 08 1999 | | | | 32. Registrar's Signature B. Sparks | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36477

| | | | | | | | | | | |
|---|---|--|---|---|--|--|--|----------------------------------|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GEORGIA DELORIS ERICSSON | | | | | 2. Date of Death Month Day Year November 4, 1999 | | 3. Time of Death 7:40 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital | | | | | 4b. City, Town, or Location of Death Frederick | | 4c. County of Death Frederick | | |
| Funeral Director | 5. Social Security Number 235-54-2251 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 63 Yrs. | 8. Date of Birth (Month, Day, Year) March 30, 1936 | 9. Birthplace (State or Foreign Country) W. Virginia | | | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Frederick | | 10c. City, Town or Location Frederick | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number 222 Broadway St., Apt. 302 | | | | 10f. Zip Code 21701 | | 10g. Citizen of What Country? United States | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress | | 16b. Kind of Business/Industry Tailor/ dry cleaner | | | | | |
| | 17. Father's Name (First, Middle, Last) Clyde Haynes | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Cozy Randolph | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Georgia D. Ericsson / daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 74 Wilderness Path / Dallas, Georgia 30132 | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory | | 20c. Location - City or Town, State 11-8-99 Hagerstown, Maryland | | | | | |
| | 21. Signature of Funeral Service Licensee <i>Raymond Peterson</i> | | | | 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702 | | | | | |
| | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cardiac Arrest</i> Due to (or as a consequence of): b. <i>Pulmonary Arrest</i> Due to (or as a consequence of): c. <i>Lung Adenocarcinoma</i> Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <i>7 minutes</i> <i>24 hours</i> <i>2 months</i> | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive Pulmonary Disease</i> | | | | | | | | | |
| State Registrar | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier <i>Alan H. Rohrer, MD</i> | | | | 29c. License number D37197 | | 29d. Date signed (Month, Day, Year) 11-7-99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>1080 W. Patrick St. Frederick, MD Alan H. Rohrer</i> | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 08 1999 | | | 32. Registrar's Signature <i>Benita B. Sparks</i> | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36478

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William C. Enck

2. Date of Death
Month Day Year
Oct. 31, 19993. Time of Death
23:37 PM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

060-12-6054

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 17, 1918

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

23121 Bank Barn Court

10f. Zip Code

20876

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Core Maker

16b. Kind of Business/Industry

Iron Foundry

17. Father's Name (First, Middle, Last)

William C. Enck, Sr.

18. Mother's Name (First, Middle, Maiden Summe)

Margaret Murray

19a. Informant's Name/Relationship (Type, Print)

Dianne J. Leiter - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23121 Bank Barn Court, Germantown, Maryland 20876

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematorium 11/4

Date

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Olin L. Molesworth

22. Name and Address of Facility

Olin L. Molesworth P.A., Funeral Home

26401 Ridge Road, Damascus, Maryland 20872-0117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arrhythmia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Renal Failure

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOAOther: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David Holden MD

29c. License number

D47791

29d. Date signed (Month, Day, Year)

November 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Holden 809 Veirs Mill Road, Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

NOV 03 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36479

| | | | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marjorie C. Fender | | | | | | 2. Date of Death Month Day Year NOVEMBER 5 1999 | | 3. Time of Death 1:55 A | | |
| | 4a. Facility Name (If not institution, give street and number) Lorien Nursing Home | | | | | | 4b. City, Town, or Location of Death Belcamp | | 4c. County of Death HARFORD | | |
| Funeral Director | 5. Social Security Number 212-14-2398 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 99 Yrs. | | 8. Date of Birth (Month, Day, Year) June 14, 1900 | | 9. Birthplace (State or Foreign Country) North Carolina | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County Harford | | 10c. City, Town or Location Aberdeen | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 765 Gilbert Road | | | | 10f. Zip Code 21001 | | 10g. Citizen of What Country? U.S.A. | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager | | | 16b. Kind of Business/Industry Restaurant | | | | |
| 17. Father's Name (First, Middle, Last) Mack Higgins | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Laura Todd | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Evon T. Brinegar (Daughter) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 765 Gilbert Road, Aberdeen, Maryland 21001 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Gardens | | 20c. Location - City or Town, State 11/8/99 Bel Air, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee Kenneth B. Camp | | | | | | 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Aspiration pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Alzheimer's disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death 2 days | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's disease | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier John L. [Signature] | | | | | | 29c. License number 128339 | | 29d. Date signed (Month, Day, Year) November 5, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. W. [Signature] 101 [Signature] Road Bel Air, MD 21001 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 08 1999 | | 32. Registrar's Signature [Signature] | | | | | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural," or items 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36480

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Lorraine Forrest

2. Date of Death

Nov. 3, 1999

3. Time of Death

10:00 A.M.

4a. Facility Name (If not institution, give street and number)

115 Water St.

4b. City, Town, or Location of Death

Thurmont

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

164-46-6469

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

44 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 3, 1955

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Md.

10b. County

Frederick

10c. City, Town or Location

Thurmont

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

115 Water St.

10f. Zip Code

21788

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Navar Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

Collega (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Factory

17. Father's Name (First, Middle, Last)

Floyd Calvin Manning

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth Welch

19a. Informant's Name/Relationship (Type, Print)

Meredith F. Forrest Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14 Tacoma St. Thurmont, Md. 21788

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Smithsburg Crematory Nov. 4, 1999

Data

20c. Location - City or Town, State

Smithsburg, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

12525 Bradbury Ave.
Davis Funeral Home
Smithsburg, Md. 2178323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. METASTATIC ADENOCARCINOMA OF PANCREAS

10 MONTHS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D31761

29d. Date signed (Month, Day, Year)

11/5/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRIAN M. O'CONNOR MD 501 W. SEVENTH ST. FREDERICK MD 21701

31. Date filed (Month, Day, Year)

NOV 09 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23b or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 36481

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clara Amelia Fairall

2. Date of Death

November 9, 1999

3. Time of Death

2351

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington County

Funeral
Director

5. Social Security Number

579-03-7454

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 16, 1914

9. Birthplace (State or Foreign Country)

Dist. of Col.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington Co.

10c. City, Town or Location

Clear Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10927 Ashton Road

10f. Zip Code

21722

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

John Gallagher

18. Mother's Name (First, Middle, Maiden Surname)

Clara Knowsky

19a. Informant's Name/Relationship (Type, Print)

Alvie Robert Fairall/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10925 Ashton Road, Clear Spring, Maryland 21722

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

Nov. 12

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

Douglas A. Fiery

22. Name and Address of Facility

Douglas A. Fiery Funeral Home
1331 Eastern Blvd., N., Hagerstown, Maryland 21742

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

pneumonia, acute

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

chronic emphysema

Due to (or as a consequence of):

decades

c.

lung cancer

Due to (or as a consequence of):

"

d.

5/2 lung resection (lobectomy)

Due to (or as a consequence of):

lifelong

bronchospasm / atopy

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - at home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dan H. McDougal

29c. License number

D21470

29d. Date signed (Month, Day, Year)

11/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAN MCDUGAL, M.D.

11110 Med. Campus Dr. Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

NOV 16 1999

32. Registrar's Signature

Genevieve B. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36482

| | | | | | | | | |
|---|--|--|---|---|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) William Bradley Fout | | | | 2. Date of Death Month October Day 29 Year 1999 | | 3. Time of Death 10:30 AM | |
| | 4a. Facility Name (If not institution, give street and number) 1418 West 11th Street | | | | 4b. City, Town, or Location of Death Frederick | | 4c. County of Death Frederick | |
| Funeral Director | 5. Social Security Number 217-12-1922 | | 6. Sex MALE <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs | | 8. Date of Birth (Month, Day, Year) June 27, 1924 | |
| | 10a. State Maryland | | 10b. County Frederick | | 10c. City, Town or Location Frederick | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| Usual Residence of Decedent | | | | | | | | |
| 10e. Street and Number 1418 West 11th Street | | | | 10f. Zip Code 21702 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WW II If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security | | | 16b. Kind of Business/Industry US Government | |
| 17. Father's Name (First, Middle, Last) Paul Fout | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mabel Mossburg | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Ruby A. Kline, sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7902 Juniper Drive, Frederick, Maryland 21702 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery, Nov. 1, 1999 | | | 20c. Location - City or Town, State Frederick, Maryland | | |
| 21. Signature of Funeral Service Licensee Richard E. Hay M00255 | | | | 22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Heart Disease years Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Casper E. Cline III | | | | 29c. License number D16428 | | 29d. Date signed (Month, Day, Year) 10/29/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Casper E. Cline III, M.D., 300 West Ninth Street, Frederick, Md. 21701 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 02 1999 | | | 32. Registrar's Signature B. Sparks | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36483

amend item 1 per phy G779 1/14/00 yg

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Orabelle Huberta CROSS Orabelle Huberta South Gross | | | | 2. Date of Death Month Day Year October 28 1999 | | 3. Time of Death 12:20 p.m. | |
| 4a. Facility Name (If not institution, give street and number) National Lutheran Home | | | | 4b. City, Town, or Location of Death Rockville | | 4c. County of Death Montgomery | |
| 5. Social Security Number 214-09-6816 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) July 10 1919 | |
| 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | | | | |
| 10b. County Washington | | 10c. City, Town or Location Hagerstown | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 1057 Beechwood Drive | | | | 10f. Zip Code 21740 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | 16b. Kind of Business/Industry Hospital | | | |
| 17. Father's Name (First, Middle, Last) Hubert Ragan South | | | | 18. Mother's Name (First, Middle, Maiden Surname) Fern Onedia Stotler | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ragan E. Gross - Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6702 Emporia Court Springfield, Va. 22152 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery | | Date 11/1/99 | | 20c. Location - City or Town, State Hagerstown, Maryland | |
| 21. Signature of Funeral Service Licensee <i>Scott M. Minnich</i> | | | | 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 | | | |

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|--|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>pneumonia</i> Due to (or as a consequence of): b. <i>congestive heart failure</i> Due to (or as a consequence of): c. <i>atrial fibrillation</i> Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death 2 days years years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>Charles W. Karesh</i> | | 29c. License number D21726 | | 29d. Date signed (Month, Day, Year) October 28, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles W. Karesh, M.D. 26033 Ridge Road Damascus, Maryland 20872 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 02 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 36484**
Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|-------|--|--|--|---|---|--|---|---|---|----|--|-------|----------------------------------|--|----------------------------------|----|-------------------------|-------|----------------------------------|--|--|----|--|--|----------------------------------|--|--|----|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EDWIN BLAIR GLESNER SR. | | | | | 2. Date of Death Month October Day 28 Year 1999 | | 3. Time of Death 6:15 PM | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | | | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 216-14-6594 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 25, 1923 | | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Williamsport | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number 16718 Virginia Avenue | | | | 10f. Zip Code 21795 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW2 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) owner/operator | | | 16b. Kind of Business/Industry Hagerstown Produce Company | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Samuel Ray Glesner | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Zinkand | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Helen L. Glesner Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16718 Virginia Avenue Williamsport, Maryland 21795 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery | | Date 11/2/99 | | 20c. Location - City or Town, State Hagerstown, Maryland | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Gerald N. Minnich 305 N. Potomac Street Hagerstown, Maryland 21740 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="0" style="width:100%;"> <tr> <td style="width:30%; vertical-align: top;"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td style="width:60%; vertical-align: top;"> <table border="0"> <tr> <td style="width:5%;">a.</td> <td style="width:75%;">Severe Chronic Obstructive Pulmonary Disease</td> <td style="width:20%;">years</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>and Respiratory Failure</td> <td>years</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> </td> </tr> </table> | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | <table border="0"> <tr> <td style="width:5%;">a.</td> <td style="width:75%;">Severe Chronic Obstructive Pulmonary Disease</td> <td style="width:20%;">years</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>and Respiratory Failure</td> <td>years</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | a. | Severe Chronic Obstructive Pulmonary Disease | years | Due to (or as a consequence of): | | | b. | and Respiratory Failure | years | Due to (or as a consequence of): | | | c. | | | Due to (or as a consequence of): | | | d. | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | <table border="0"> <tr> <td style="width:5%;">a.</td> <td style="width:75%;">Severe Chronic Obstructive Pulmonary Disease</td> <td style="width:20%;">years</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>and Respiratory Failure</td> <td>years</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | a. | Severe Chronic Obstructive Pulmonary Disease | years | Due to (or as a consequence of): | | | b. | and Respiratory Failure | years | Due to (or as a consequence of): | | | c. | | | Due to (or as a consequence of): | | | d. | | | | | | | | | | | |
| a. | Severe Chronic Obstructive Pulmonary Disease | years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. | and Respiratory Failure | years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | | 29c. License number DO1062 | | 29d. Date signed (Month, Day, Year) October 29, 1999 | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item-29d) (Type, Print) Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, MD 21740 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 01 1999 | | | 32. Registrar's Signature  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36485

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|--|--|--|---|--|---|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Elizabeth Jane GREENLEE | | | | | | 2. Date of Death Month Day Year November 1, 1999 | | 3. Time of Death 2:25 PM | | | |
| | 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | | | | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington | | | |
| Funeral Director | 5. Social Security Number 220-42-3518 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 59 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 24, 1940 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Clear Spring | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number 23 Main Street | | | | 10f. Zip Code 21722 | | 10g. Citizen of What Country? USA | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (14 or 5+) 0 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) quality control | | | 16b. Kind of Business/Industry ribbon company | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Thomas S. Johnson | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Mullin | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) John R. Greenlee - son | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 574, Clear Spring, Md. 21722 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery | | 20c. Date 11-4-99 | | 20d. Location - City or Town, State Hagerstown, Maryland | | | | | |
| | 21. Signature of Funeral Service Licensee <i>Scott M. Minich</i> | | | | | | 22. Name and Address of Facility MINNICH FUNERAL HOME 15 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Respiratory Failure</i> Due to (or as a consequence of): b. <i>Non-Hodgkins Lymphoma</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death 1 day 5 yrs | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| State Registrar | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29c. License number 23023 | |
| | 29b. Signature and title of certifier <i>Dr. Kass</i> | | | | | | 29d. Date signed (Month, Day, Year) November 3, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dr. Kass 11110 Medical Campus Rd. Htg - Md.</i> | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 03 1999 | | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36486

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|--|------------------------------|---|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Gladys Marie Gray | | | | 2. Date of Death Month October Day 26 Year 1999 | | 3. Time of Death 4:30am | | | | |
| | 4a. Facility Name (If not institution, give street and number) 3000 Pfefferkorn Road | | | | 4b. City, Town, or Location of Death West Friendship | | 4c. County of Death Howard | | | | |
| Funeral Director | 5. Social Security Number 216-07-4022 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept 6, 1914 | | | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Howard | | 10c. City, Town or Location West Friendship | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 3000 Pfefferkorn Road | | | | 10f. Zip Code 21794 | | 10g. Citizen of What Country? United States | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | | 16b. Kind of Business/Industry Cotton Mill | | | | |
| 17. Father's Name (First, Middle, Last) Arthur Vipperman | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elsie Schneider | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Earl M. Gray/Husband | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3000 Pfefferkorn Road West Friendship, MD 21794 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Good Shepherd Cemetery | | Date 10-29-99 | | 20c. Location - City or Town, State Ellicott City, MD | | | | |
| 21. Signature of Funeral Service Licensee  | | | | | 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cerebrovascular Accident Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death Acute | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier  | | | | 29c. License number D25947 | | 29d. Date signed (Month, Day, Year) October 26, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Evelyn Jackson, MD 5540 Ten Oaks Road Clarksville, MD 21029 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) OCT 26 1999 | | | 32. Registrar's Signature  | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36487

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thurston Eugene Grim

2. Date of Death

November 1, 1999

3. Time of Death

11:15 PM

4a. Facility Name (If not institution, give street and number)

2221 Dargan Road

4b. City, Town, or Location of Death

Sharpsburg

4c. County of Death

Washington

5. Social Security Number

236-62-0532

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 23, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Washington

10c. City, Town or Location

Sharpsburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2221 Dargan Road

10f. Zip Code

21782

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1948-1968

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Soldier

16b. Kind of Business/Industry

U. S. Army

17. Father's Name (First, Middle, Last)

Marvin Arthur Grim

18. Mother's Name (First, Middle, Maiden Surname)

Sarah McGowan

19a. Informant's Name/Relationship (Type, Print)

Amelia A. Grim, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2221 Dargan Road - Sharpsburg, MD 21782

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Samples Manor Cemetery

Date

11/4/99

20c. Location - City or Town, State

Sharpsburg, MD

21. Signature of Funeral Service Licensee

Robert L. Spencer

22. Name and Address of Facility

Eackles-Spencer Funeral Home
Harpers Ferry, WV 25425

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMA OF THE LUNG

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 YRS.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edward W. Ditto, III, M.D.

29c. License number

D01062

29d. Date signed (Month, Day, Year)

November 5, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Edward W. Ditto, III, M.D. - 217 W. Washington Street - Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

NOV 08 1999

32. Registrar's Signature

B. Spauld

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36488

Hilda Giles SS# 220-76-3413
Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

| | | | | | | | | | | | | | | | |
|--|--|--------------------------------|---|---|--|--|--------------------------------|---|--------------------------------|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Hilda Giles | | | | 2. Date of Death Month October Day 30 Year 1999 | | | | 3. Time of Death 1620 | | | | | | | |
| 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | | | 4b. City, Town, or Location of Death SALISBURY | | | | 4c. County of Death WICOMICO | | | | | |
| 5. Social Security Number 220-76-3413 | | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 57 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) 11-29-1941 | | 9. Birthplace (State or Foreign Country) Md. | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | |
| 10a. State Md. | | 10b. County Wicomico | | | 10c. City, Town or Location Salisbury | | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number Snowhill Road | | | | | | 10f. Zip Code 21802 | | | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0 | | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None | | | | 16b. Kind of Business/Industry None | | | | | |
| 17. Father's Name (First, Middle, Last) Bennett E. Giles | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Florence Banks | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Robert Giles, Brother | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 512 Haverford Drive, Columbus, Ga. 31907 | | | | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cambridge Crematory | | | | Date 11-2-99 | | 20c. Location - City or Town, State Cambridge, Md. | | | | | |
| 21. Signature of Funeral Service Licensee <i>William M. Short</i> | | | | | | 22. Name and Address of Facility Short Funeral Home, Inc. 700 W. St. Laurel, De. 19956 | | | | | | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>a. <i>Ruptured, perforated Colon -</i> Due to (or as a consequence of):</p> <p>b. <i>probable Colon volvulus</i> Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> </div> | | | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Severe mental retardation, long term institutionalization</i> <i>Severe chronic constipation</i> | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| | | | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | | | | |
| | | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <i>John A. Routenburg</i> | | | | 29c. License number 15857 | | 29d. Date signed (Month, Day, Year) 10/31/99 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. John Routenburg 205 S. Division Street Salisbury Md. 21801 | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 02 1999 | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | | | | | | |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36489

| | | | | | |
|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GLENN A Ruth | | 2. Date of Death Month Day Year NOVEMBER 6, 1999 | | 3. Time of Death 11:40 AM |
| | 4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore |
| Funeral Director | 5. Social Security Number 214-34-0626 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 63 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) Dec. 5, 1935 | | 9. Birthplace (State or Foreign Country) West Virginia | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 10e. Street and Number 1801 Wentworth Road | | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? U.S.A. |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: white | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0-12 College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) chief clerk | | 16b. Kind of Business/Industry correctional | |
| 17. Father's Name (First, Middle, Last) Hubert C. Smith | | | 18. Mother's Name (First, Middle, Maiden Surname) Ruth Ketterman | | |
| 19a. Informant's Name/Relationship (Type, Print) Mr. Bradley Hajek/son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Colonial Court, Littlestown, Pennsylvania 17340 | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery | | 20c. Location - City or Town, State Nov. 11, 1999 Hagerstown, Maryland | |
| 21. Signature of Funeral Service Licensee Frederick L. Vester | | 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | | | | |
| a. SEPTIC SHOCK. | | | | | |
| Due to (or as a consequence of): | | | | | |
| b. UROSEPSIS | | | | | |
| Due to (or as a consequence of): | | | | | |
| c. PNEUMONIA. | | | | | |
| Due to (or as a consequence of): | | | | | |
| d. DEMENTIA. | | | | | |
| Approximate Interval Between Onset and Death < 24 hrs UNKNOWN UNKNOWN UNKNOWN | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PNEUMOTHORAX | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier Frederick L. Vester MD | | 29c. License number P-11389 | | 29d. Date signed (Month, Day, Year) NOVEMBER 6, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GILBERT DONAHUE, 6935 DONACHIE RD APT 6, BALTIMORE-MD 21239 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 09 1999 | | 32. Registrar's Signature B. Sparks | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36490

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EARL JACOB HEGE

2. Date of Death

Month Day Year
NOVEMBER 2, 1999

3. Time of Death

1:05PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

National Institute of Health

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

164-46-6911

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 23, 1950

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Pa.

10b. County

Franklin

10c. City, Town or Location

Chambersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3966 Funk Road

10f. Zip Code

17201

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8+

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Paul Hege

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Heatwole

19a. Informant's Name/Relationship (Type, Print)

Lucy Hege/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3966 Funk Rd., Chambersburg, Pa. 17201

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Culbertson Cemetery

Date

Nov. 5

20c. Location - City or Town, State

Chambersburg, Pa.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Douglas A. Fiery Funeral Home

1331 Eastern Blvd. N, Hagerstown, Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolus

Due to (or as a consequence of):

b. Inferior Vena Cava Tumor Thrombus

Due to (or as a consequence of):

c. Metastatic Renal Cell Carcinoma

Due to (or as a consequence of):

d.

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

History of Pulmonary embolus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)
N.A.

28b. Time of Injury

N.A. M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

N.A.

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

N.A.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N.A.

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

J9736 (TEXAS)

29d. Date signed (Month, Day, Year)

November 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FREDRICK S. LEACH 9000 ROCKVILLE PIKE, BETHESDA, MD 20892

31. Date filed (Month, Day, Year)

NOV 04 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Page 11 of 12

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36491

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Rebecca Holsinger

2. Date of Death

October 31, 1999

3. Time of Death

5:45 a.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Homewood Retirement Center

4b. City, Town, or Location of Death

Williamsport

4c. County of Death

Washington

5. Social Security Number

215-20-8106

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

October 1, 1909

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Maugansville

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

13737 Village Mill Drive

10f. Zip Code

21767

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

meat cutter

16b. Kind of Business/Industry

Holsinger's Meat Market

17. Father's Name (First, Middle, Last)

Harry Fisher Biesecker

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Grace Bachtell

19a. Informant's Name/Relationship (Type, Print)

Robert E. Holsinger, Sr. Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17903 Bluebell Court Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

Date

11/3/99

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gerald N. Minnich 305 N. Potomac Street
Funeral Home Hagerstown, Maryland 21740

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Stroke

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate interval Between Onset and Death

days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary emboli, deep vein thrombosis
myocardial infarction, seizure disorder
Arteriosclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

1 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D26806

29d. Date signed (Month, Day, Year)

11/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Holsinger's 747 North Ave Hagerstown MD 21742

31. Date filed (Month, Day, Year)

NOV 01 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36492

| | | | | | | | | |
|--|--|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Anna Kathryn HILL | | | | 2. Date of Death Month Day Year OCTOBER 31, 1999 | | 3. Time of Death 10:25 AM | |
| | 4a. Facility Name (If not institution, give street and number) RAVENWOOD LUTHERAN VILLAGE | | | | 4b. City, Town, or Location of Death HAGERSTOWN | | 4c. County of Death WASHINGTON | |
| Funeral Director | 5. Social Security Number 213-18-8406 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 11 1919 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Hagerstown | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 1183 Luther Drive | | 10f. Zip Code 21740 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Her Own Home | | | | |
| 17. Father's Name (First, Middle, Last) Raymond Purnell | | | | 18. Mother's Name (First, Middle, Maiden Surname) Maude Clark | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Donna M. Wieland - Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16619 Johnson Drive Williamsport, Maryland 21795 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery | | 20c. Date 11/3/99 | | 20d. Location - City or Town, State Hagerstown, Maryland | | |
| 21. Signature of Funeral Service Licensee <i>Scott Minnich</i> | | | | 22. Name and Address of Facility Minnich Funeral Home 15 E. Wilson Blvd. Hagerstown, Maryland 21740 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Parkinson's Disease</i> Due to (or as a consequence of): b. <i>Pneumonia</i> Due to (or as a consequence of): c. <i>X</i> Due to (or as a consequence of): d. <i>X</i> | | Approximate Interval Between Onset and Death 10 yrs. 1 week X d | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | |
| | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Manzar J Shah</i> | | 29c. License number D28365 | | 29d. Date signed (Month, Day, Year) 11-1-99. | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manzar J SHAH 368 HILL ST Hagerstown MD 21742. | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 02 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) ELMER CLEVELAND HULL, SR | | 2. Date of Death Month NOVEMBER Day 6 , Year 1999 | | 3. Time of Death 0645 | |
| 4a. Facility Name (If not institution, give street and number) University of Maryland | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore | |
| 5. Social Security Number 203-10-4356 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | |
| 8. Date of Birth (Month, Day, Year) May 4, 1922 | | 9. Birthplace (State or Foreign Country) Waynesboro, PA | | | |
| 10a. State PA | | 10b. County Franklin | | 10c. City, Town or Location Waynesboro | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 237 West Second Street | | 10f. Zip Code 17268 | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | |
| 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesperson | | 16b. Kind of Business/Industry Freight Co | | 17. Father's Name (First, Middle, Last) Grover C. Hull | |
| 18. Mother's Name (First, Middle, Maiden Surname) Ella Rosetta Shives | | 19a. Informant's Name/Relationship (Type, Print) E. Marie Hull | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 237 W Second ST Waynesboro PA 17268 | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Hill Cemetery | | 20c. Location - City or Town, State Nov 10 Waynesboro PA | |
| 21. Signature of Funeral Service Licensee James A. Bowersox | | 22. Name and Address of Facility Grove Funeral Home, Inc. 50 S Broad ST Waynesboro PA 17268 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Ruptured Abdominal Aortic Aneurysm Due to (or as a consequence of): | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) Nov 10 1999 | |
| 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| 29b. Signature and title of certifier Cynthia D. Nelms MD | | 29c. License number P 09796 | | 29d. Date signed (Month, Day, Year) November 6, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia D. Nelms, MD 22 S. Greene ST Baltimore MD 21210 | | 31. Date filed (Month, Day, Year) NOV 10 1999 | | 32. Registrar's Signature B. Sparks | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36494

| | | | | | | | | | |
|---|--|---|--|---|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary V. Howes | | | | 2. Date of Death Month October Day 25 Year 1999 | | 3. Time of Death 12:15pm | | |
| | 4a. Facility Name (If not institution, give street and number) 10093 Maplewood Drive | | | | 4b. City, Town, or Location of Death Ellicott City | | 4c. County of Death Howard | | |
| Funeral Director | 5. Social Security Number 578-20-8463 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) March 2, 1921 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10. Usual Residence of Decedent 10a. State Maryland 10b. County Worcester 10c. City, Town or Location Ocean City 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Programmer | | 16b. Kind of Business/Industry Social Security Administration | |
| 17. Father's Name (First, Middle, Last) Francis M. Hawkins | | | | 18. Mother's Name (First, Middle, Maiden Surname) Birdie V. Oland | | | | 19. Informant's Name/Relationship (Type, Print) Charles R. Howes/Husband | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | 20c. Location - City or Town, State 10-26-99 Catonsville, MD | | 21. Signature of Funeral Service Licensee Steve A. Collins - Witzke | |
| 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home 4112 Old Columbia Pike Ellicott City, MD | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Parkinson's disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | |
| 28b. Time of Injury M | | | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how Injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| 29b. Signature and title of certifier Joseph F. Gibbons, MD | | | | 29c. License number D38296 | | | | 29d. Date signed (Month, Day, Year) Oct. 26, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH F. GIBBONS, MD 9501 OLD ANNAPOLIS RD, ELICOTT CITY, MD 21042 | | | | 31. Date filed (Month, Day, Year) OCT 26 1999 | | | | 32. Registrar's Signature Beverly G. Sparks | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36495

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) William A. Hylton | | | | 2. Date of Death Month November Day 1 Year 1999 | | 3. Time of Death 8:00pm | |
| 4a. Facility Name (If not institution, give street and number) 5685 Harpers Farm Road Apt A | | | | 4b. City, Town, or Location of Death Columbia | | 4c. County of Death Howard | |
| 5. Social Security Number 217-26-6320 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) June 22, 1916 | |
| 9. Birthplace (State or Foreign Country) Virginia | | 10a. State Maryland | | 10b. County Howard | | 10c. City, Town or Location Columbia | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 5685 Harpers Farm Road Apt A | | 10f. Zip Code 21044 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cattle Broker | | 16b. Kind of Business/Industry Self Employed | | | |
| 17. Father's Name (First, Middle, Last) Walter Hylton | | | | 18. Mother's Name (First, Middle, Maiden Surname) Susan Hurst | | | |
| 19a. Informant's Name/Relationship (Type, Print) William A. Hylton Jr./Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21201 One Charles Center 100 N Charles St Ste 630 Balt MD | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | 20c. Location - City or Town, State 11-2-99 Catonsville, MD | | 21. Signature of Funeral Service Licensee Shirley A. Collins-Witzke | |
| 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 18 years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. BRONCHOGENIC CARCINOMA | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier B. Sparks | | 29c. License number D0018317 | | 29d. Date signed (Month, Day, Year) November 2, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BERNARD P. FARRELL MD 11055 LITTLE PATUXENT PARKWAY COLUMBIA MD 21044 | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 02 1999 | | 32. Registrar's Signature B. Sparks | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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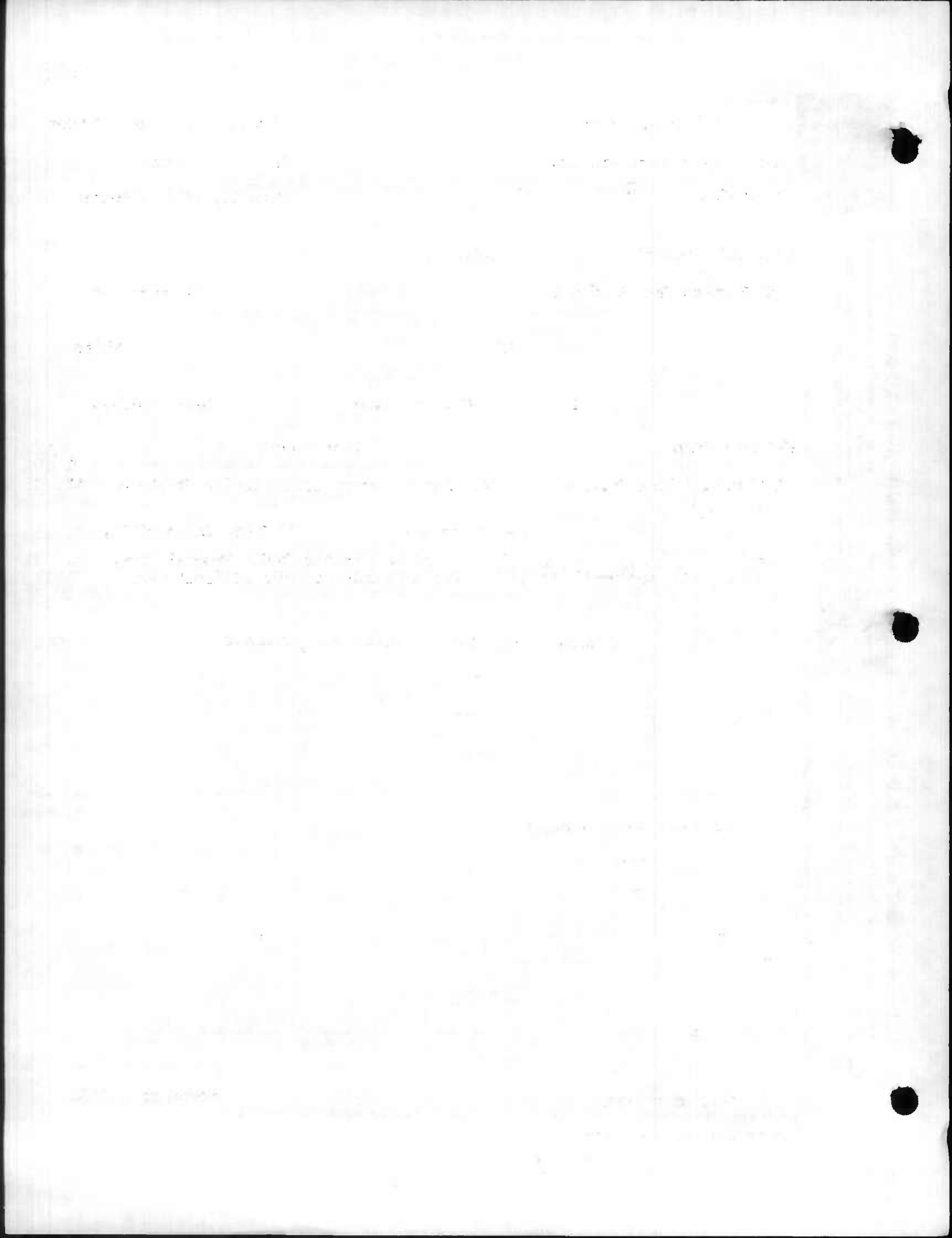
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36496

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lawrence L. HALTER

2. Date of Death

Oct, 12, 1999

Day Year

3. Time of Death
8:45 am

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

453-47-3133

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Aug 2, 1949

9. Birthplace (State or Foreign Country)

Australia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8460 Roberts Road

10f. Zip Code

21043

10g. Citizen of What Country?

Australia

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Charles Francis Ray Halter

18. Mother's Name (First, Middle, Maiden Surname)

Patricia G. Jackson

19a. Informant's Name/Relationship (Type, Print)

Kathleen M. Halter/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8460 Roberts Road Ellicott City, Md 21043

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

10-16-99

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

Sharon A. Collins-Witzke

22. Name and Address of Facility

Harry H. Witzke's Family Funeral Home, Inc.
4112 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma Undetermined Primary Site 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Knight

29c. License number

241139

29d. Date signed (Month, Day, Year)

October, 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard County Gen Hospital, Columbia, MD 21044

31. Date filed (Month, Day, Year)

OCT 15 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#26per doctor, 11/4/1999 **Certificate of Death** FCHD, KS Reg. No. 99 36497

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|---|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last) BEULAH VIRGINIA HAMMER | | | 2. Date of Death Month Day Year October 26, 1999 | | 3. Time of Death 8:05 PM | | |
| 4a. Facility Name (If not institution, give street and number) NORTHAMPTON MANOR NURSING HOME | | | 4b. City, Town, or Location of Death FREDERICK | | 4c. County of Death FREDERICK | | |
| 5. Social Security Number 577-54-2861 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 93 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept 21, 1906 | |
| 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Frederick | | 10c. City, Town or Location Frederick | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 404 East 9th Street | | 10f. Zip Code 21701 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (14 or 5+) - | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesperson | | 16b. Kind of Business/Industry Appliance Store | | 17. Father's Name (First, Middle, Last) William E. Neil | |
| 18. Mother's Name (First, Middle, Maiden Surname) Nettie Virtz | | 19a. Informant's Name/Relationship (Type, Print) Kenneth N. Bruchey / nephew | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 East 9th Street, Frederick, MD 21701 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery | | 20c. Date 10/29/99 | | 20d. Location - City or Town, State Frederick, Maryland | | 21. Signature of Funeral Service Licensee | |
| 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ALZHEIMERS DEMENTIA Due to (or as a consequence of): | | 23b. Approximate Interval Between Onset and Death 5 years | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 23d. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 23e. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 24. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 26. Place of Death (Check only one) <input checked="" type="checkbox"/> Hospital <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 10/27/99 | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D32171 | | 29d. Date signed (Month, Day, Year) 10/27/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Richard L. Gough 19 Frederick Street, Walkersville, MD 21793 | | 31. Date filed (Month, Day, Year) OCT 28 1999 | | 32. Registrar's Signature | | 33. State Registrar | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36498

| | | | | | | | | | | | |
|--|---|---|--|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary Ellen Harris | | | | 2. Date of Death Month Day Year October 29, 1999 | | | | 3. Time of Death 3:15 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital | | | | 4b. City, Town, or Location of Death Takoma Park | | | | 4c. County of Death Montgomery | | |
| Funeral Director | 5. Social Security Number 220-16-3158 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 73 Yrs. | | 8. Date of Birth (Month, Day, Year) November 25, 1925 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Frederick | | 10c. City, Town or Location Frederick | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number 707 East South Street | | | | 10f. Zip Code 21701 | | | | 10g. Citizen of What Country? United States | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bartender | | | | 16b. Kind of Business/Industry Restaurant | | | |
| 17. Father's Name (First, Middle, Last) Melvin Nusz | | | | 18. Mother's Name (First, Middle, Maiden Surname) Bertha Suter | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Patricia Mercer/ Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4501 Pine Valley Court, Middletown, Maryland 21769 | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory | | Date October 31, 1999 | | 20c. Location - City or Town, State Smithsburg, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Keeney and Basford Funeral Home 106 East Church Street Frederick, MD 21701 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death) a. Aortic Dissection Due to (or as a consequence of): | | | | | | | | | | 2 Days | |
| b. Cystic Medical Necrosis Due to (or as a consequence of): | | | | | | | | | | 70 Years | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): | | | | | | | | | | | |
| d. Due to (or as a consequence of): | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 26a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier  ANJUM G. QAZI, MD | | | | 29c. License number D28883 | | 29d. Date signed (Month, Day, Year) October 29, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anjum G. Qazi, M.D. 7600 Carroll Avenue, Takoma Park, Maryland 20912 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 08 1999 | | 32. Registrar's Signature  | | | | | | | | | |

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 36499

AMEND ITEM 7 11-8-99 HCHD BH Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LEON WINFIELD JONES | | | | 2. Date of Death Month NOV Day 2 Year 1999 | | 3. Time of Death 8:27 | |
| | 4a. Facility Name (If not institution, give street and number) HARFORD MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death HAVRE DE GRACE | | 4c. County of Death HARFORD | |
| Funeral Director | 5. Social Security Number 218-38-2742 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 56 Yrs. | | 8. Date of Birth (Month, Day, Year) NOV-21-1942 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MD | | 10b. County HARFORD | | 10c. City, Town or Location HAVRE DE GRACE | |
| Usual Residence of Decedent 11-21-1942 | | 10e. Street and Number 151 BLOOMSBURY AVE | | 10f. Zip Code 21078 | | 10g. Citizen of What Country? US | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 12/20/61 to 2/20/66 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: BLACK | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MACHINE OPERATOR | | 16b. Kind of Business/Industry FACTORY | | 17. Father's Name (First, Middle, Last) CORNELIUS JONES SR | | |
| 18. Mother's Name (First, Middle, Maiden Summa) MARGARET STEWART | | 19e. Informant's Name/Relationship (Type, Print) ANTOINETTE JACKSON | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 151 BLOOMSBURY AVE HAVRE DE GRACE, MD 21078 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) CARRISON FOREST CEMT. | | Date 11.8.99 | | 20c. Location - City or Town, State OWINGS MILL, MD | | 21. Signature of Funeral Service Licensee Rita Scott | | |
| 22. Name and Address of Facility BEARD FUNERAL HOME | | 333 LEWIS ST HAVRE DE GRACE, MD 21078 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pulmonary Embolism DVT | | Approximate Interval Between Onset and Death | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Thomas A. Blom | | 29c. License number D42800 | | 29d. Date signed (Month, Day, Year) 11/4/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas A. Blom MD 319 S. Union Ave, #66, 21078 | | 31. Date filled (Month, Day, Year) NOV 08 1999 | | 32. Registrar's Signature Benjamin B. Sparks | | | | |

ORIGINAL

NOV 8 1967

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 36500

| | | | | | | | | |
|--|---|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) VIVIAN J. JOHNSON | | | | 2. Date of Death Month Day Year OCT 15 1999 | | 3. Time of Death 2:30 PM | |
| | 4a. Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death COLUMBIA, MD | | 4c. County of Death HOWARD | |
| Funeral Director | 5. Social Security Number 224-28-4470 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 9, 1921 | 9. Birthplace (State or Foreign Country) Scotland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Howard | | 10c. City, Town or Location Ellicott City | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 2530 McKenzie Road | | | | 10f. Zip Code 21042 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | |
| | 17. Father's Name (First, Middle, Last) George Dickson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Helen Robertson | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Darrell H. Johnson/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2530 McKenzie Road Ellicott City, MD 21042 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn Cemetery | | Date 10-18-99 | | 20c. Location - City or Town, State Marriottsville, MD | |
| | 21. Signature of Funeral Service Licensee Soma Collins-Witzke | | | | 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) a. SEPTIC SHOCK Due to (or as a consequence of): b. ASPIRATION PNEUMONIA Due to (or as a consequence of): c. DEMENTIA Due to (or as a consequence of): d. | | | | | | | 1 DAY 1 WEEK 36 MONTHS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE TRIPLE CARDIAC VALVE REPLACEMENT | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier G. Wadhavkar MD | | 29c. License number D0053078 | | 29d. Date signed (Month, Day, Year) OCT 15, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. WADHAVKAR, MD 9501 OLD ANNAPOLIS RD #200 ELLICOTT CITY 21042 | | | | | | | | |
| 31. Date filed (Month, Day, Year) OCT 18 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State
Registrar

